ATTACHMENT C

Current Business Model and Risks

Current Business Model

The current mission statement of Office of Risk Management promises all things to all people. It implies an element of control that the organization really does not have. The Office of Risk Management lacks any coercive power over the various state agencies, boards and commission that contribute to the total claim volume it handles each year. It is responsible for handling existing claims to conclusion. In that regard, the mission is clearly stated. The organization needs to do more to ensure that claims that occur are resolved more professionally than could happen elsewhere. That is not happening now.

The Office of Risk Management must be the analyst of new claims reported. As one risk manager put it, "I am really the news person. I determine what is happening and tell the boss about it. He takes action after that." This concept underlies the analytical role so necessary for a state risk management agency. Here again, the Office of Risk Management has not excelled. Numerous state officials indicated through their comments that the organization had "… failed to convey the appropriate message…" or "…lacked the ability to quantify what they were saying…". One official described in detail the exasperating difficulties encountered in getting basic data quickly. The same difficulties were encountered during the assessment. Indeed, even now the accuracy of some numbers used in this very report can be categorized as questionable.

The Office of Risk Management is well-positioned to become a most remarkable entity from a claims handling and loss analysis standpoint. There is no reason why this organization, given the proper leadership, adequate training and adequate technological resources, could not outperform any similar entity.

There is the equal potential for this report, like an Office of Risk Management safety audit, to quickly begin to gather dust on some office shelf. The difference will be in resolve and commitment. The organization needs to refine itself. The gap between "getting by" and "getting high" is not great. High-performing organizations are committed to clearly articulated standards of excellence. These standards are not presently found within this organization but could be instilled within a year or two. If there is to be time for the work that is needed, unnecessary work will have to be discarded or optimized with automation. Letting go of the current culture sounds promising but, in practice, is never easy or comfortable. It will take keen and progressive leadership.

The mission, once refined, will need to be promoted daily and supported in every possible way. Other state risk management agencies can provide baselines. While none of the states surveyed proved to have overall organizational and operational excellence, each one has produced something notable and useful. The State of Nevada has a great website. Georgia has solid operating performance outcomes. Minnesota is solid on mission and metrics while Texas excels in systems and metrics.

At one extreme, the Office of Risk Management could become a gatherer of numbers for the Legislature with individual clients handling their own affairs. As with some states surveyed, the Office of Risk Management might be charged with handling only a certain class of claim, perhaps workers' compensation or automobile, leaving client agencies, boards and commissions free to go elsewhere for other services.

At the other extreme, the Office of Risk Management might continue in current form but hand over daily operations to a third-party administrator (TPA). This is a common form among some of the states surveyed. The Office of Risk Management becomes the chief administrator but is removed from the day-to-day professionalism so needed in a modern claims environment.

A hybrid organization is also possible. Some states have chosen to employ on-site TPAs who function much like employees but retain their separate identity. Again, the Office of Risk Management would function as the chief coordinator.

The Office of Risk Management sees itself as a full service risk management entity but its reliance on independent claim handlers, though seen as a necessary response to severe staffing reductions, does warrant further review for its implications on the true mission of this organization. The new leadership must tackle this issue as a high priority and make the appropriate decision.

Executive Organization

Whitman Kling and Patricia Reed began serving as Interim State Risk Director and Interim Assistant State Risk Director respectively in February 2002 with the departure of Seth Keener and Evon Wise. Mr. Kling has dual responsibility as the Deputy Undersecretary for the Division of Administration. Mr. Kling had previously served as State Risk Director in the early 1980's. Ms. Reed had served as the Underwriting Unit Head prior to this appointment.

The Office of Risk Management is divided into five units:

- Administration
- Underwriting
- Claims
- Loss Prevention
- Accounting

Satellites offices have been established in Lafayette, New Orleans, Shreveport, Lake Charles and Alexandria/Pineville and are staffed by Loss Prevention and Claims personnel.

The Office of Risk Management currently has 124* staff members.

Executive Management	Middle Management	Professional / Technical	Clerical	Students
2	18	76	18	10

**All staffing numbers are approximate since additions, separations and transfers are constantly occurring.*

Administrative Unit

Anne Gianelloni leads the Administrative Unit. This unit is comprised of:

Administrative Specialist 1	1
Executive Services Assistant	1
Clerk 4	1
Clerk Chief 1	1
Clerk Chief 2	1
IT Application Programmer/Analyst 2	1*
IT Management Consultant 1	1**
IT Liaison Officer	1*
IT Equipment Operator 3	1*
Total Staff	**10**

* These individuals report directly to the Assistant State Risk Director.
** This individual has a dual reporting responsibility to the Office of Information Services and the Assistant State Risk Director.

SUMMARY OF FINDINGS AND RECOMMENDATIONS

This unit provides administrative support to the executive management team, staffs the Medical Review Panel and provides technology-related services to the entire office staff.

The lack of receptionist/clerical support at this level was identified as a weakness within the organization. Vacancies in this area need to be promptly addressed.

The placement of the Medical Review Panel within the management structure of the Office of Risk Management seems inappropriate based on its stated responsibilities. This function should be realigned at the Division of Administration level, with additional staff support, to avoid any undue appearance of impropriety with the objective handling of claims against the State.

The individuals responsible for supporting the information technology and telecommunications needs for the Office of Risk Management have proven to be supportive to the organization despite the lack of sufficient resources. These individuals should be more proactively involved and assigned some level of accountability in the acquisition of technology-related products and services.

Underwriting Unit

Tommy Arbour was promoted to State Risk Underwriting Manager in February 2002. The unit is comprised of:

State Risk Underwriting Supervisor	2
State Risk Underwriter 3	1
State Risk Underwriter 1	1
Clerk Chief 1	2
Total Staff	**7**

SUMMARY OF FINDINGS AND RECOMMENDATIONS

The following subsections summarize the overall findings and recommendations generated as a result of this assessment.

BUDGETING

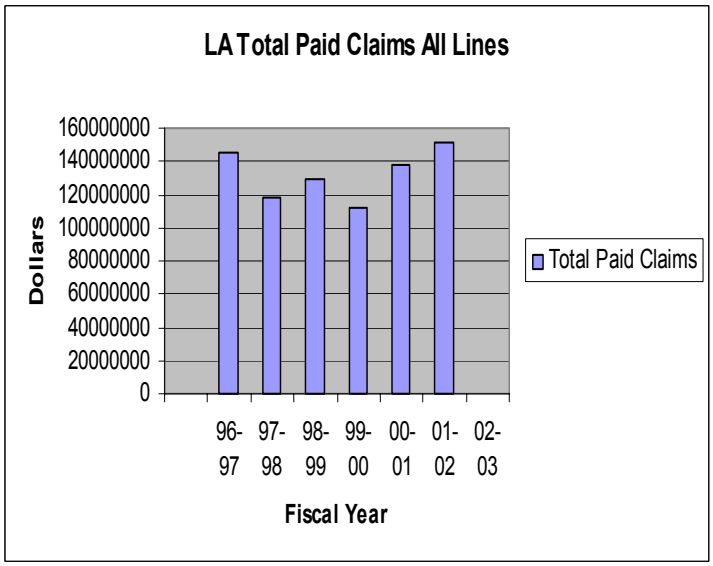
It appears that a lack of detail in the communication of budget needs has resulted in a disconnect between the Office Risk Management, the Office of Planning and Budget (OPB), the House Fiscal Division and the Joint Legislative Committee on the Budget. To improve these communications, a recommendation has been prepared for the funding of the Office Risk Management in the 02-03 fiscal year as well as for special loss prevention initiatives. A framework for communication of future year budget needs is also being recommended.

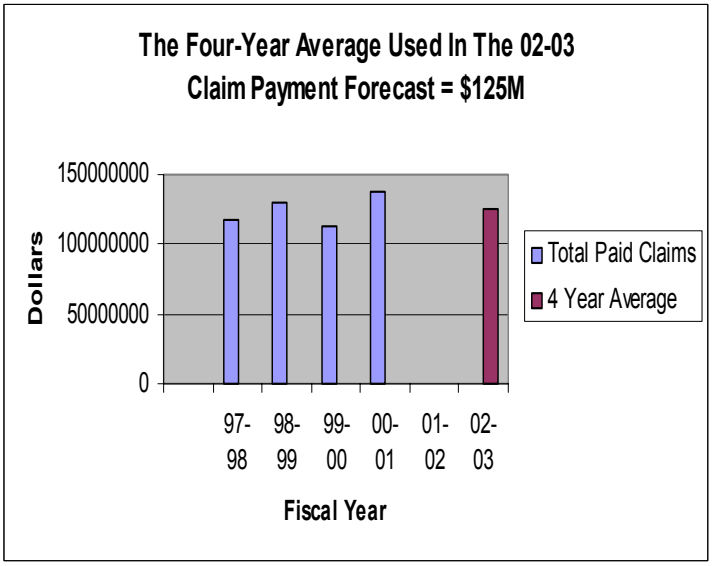
02-03 FISCAL YEAR BASIC FUNDING

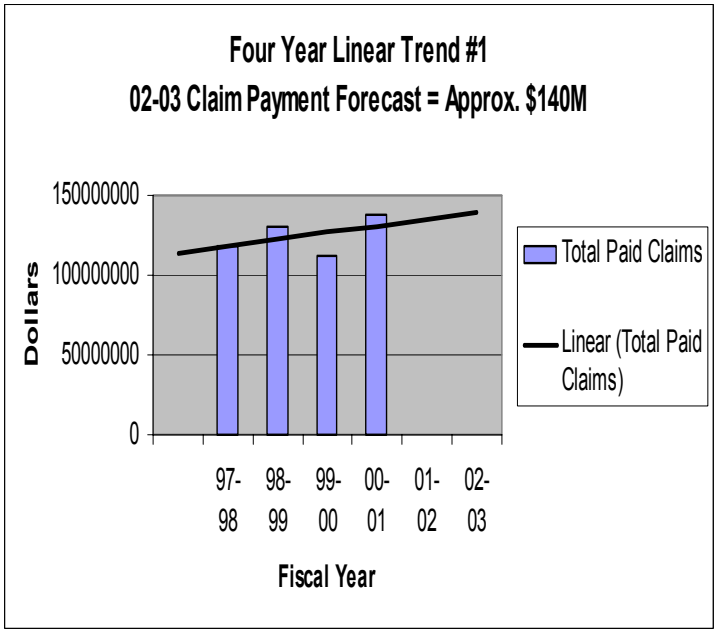
FISCAL YEAR 02-03 Office of Risk Management BUDGET ESTIMATES

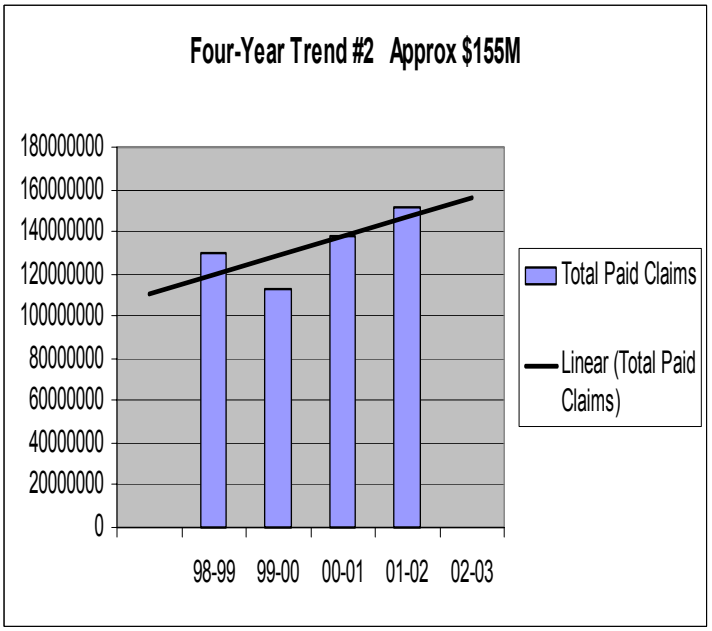
	(in millions)
CLAIM PAYMENT CASH NEED	$ 152
ORM ADMINISTRATION	$ 8
COMMERCIAL INSURANCE	$ 20
CASH NEED FOR 02-03	$ 180
2 YEAR CASH RESERVE	$ 360
1/4 RESERVE NEED FUNDING	$ 90
RECOMMENDED Office of Risk Management FUNDING FOR 02-03	$ 270

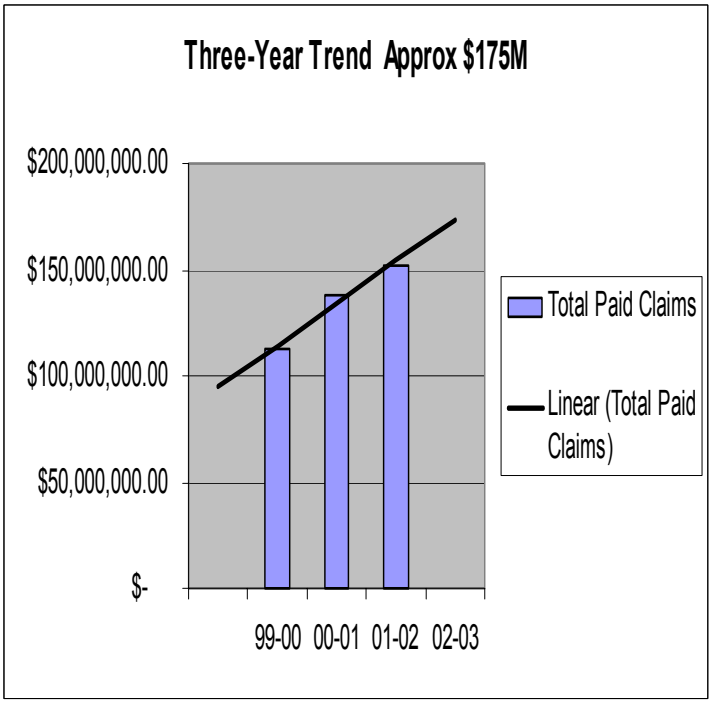
The Claim Payment Cash Need for 02-03 is based on a study of trends in the claim payment amounts for all coverage lines in recent years. The several methods used are illustrated and summarized in the following charts.

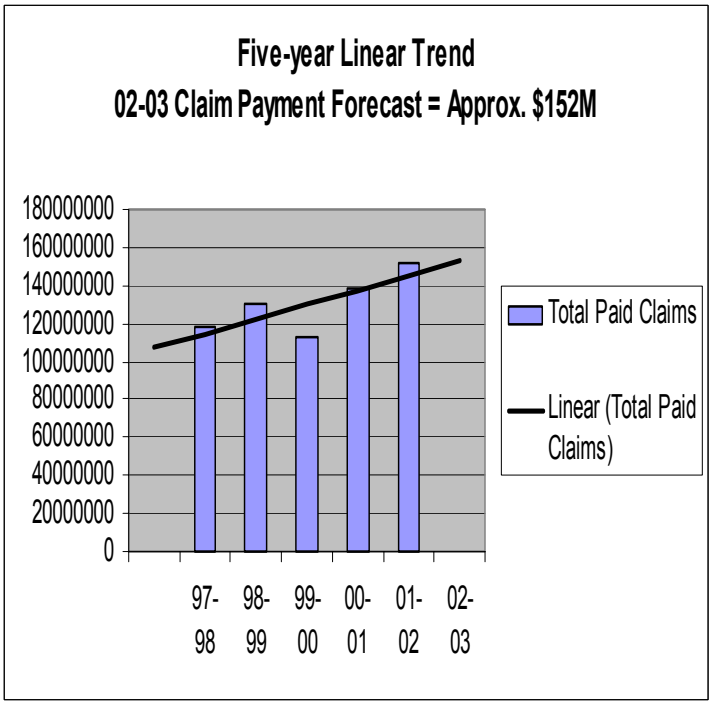


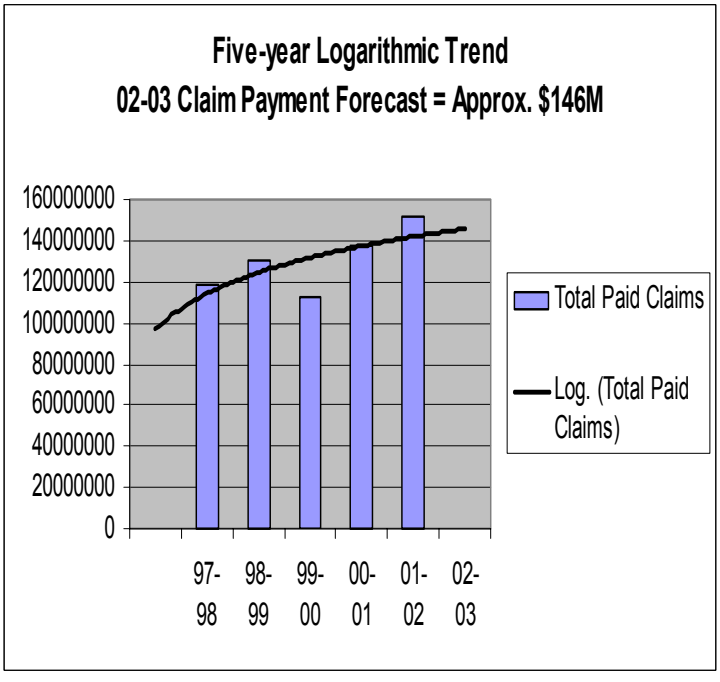


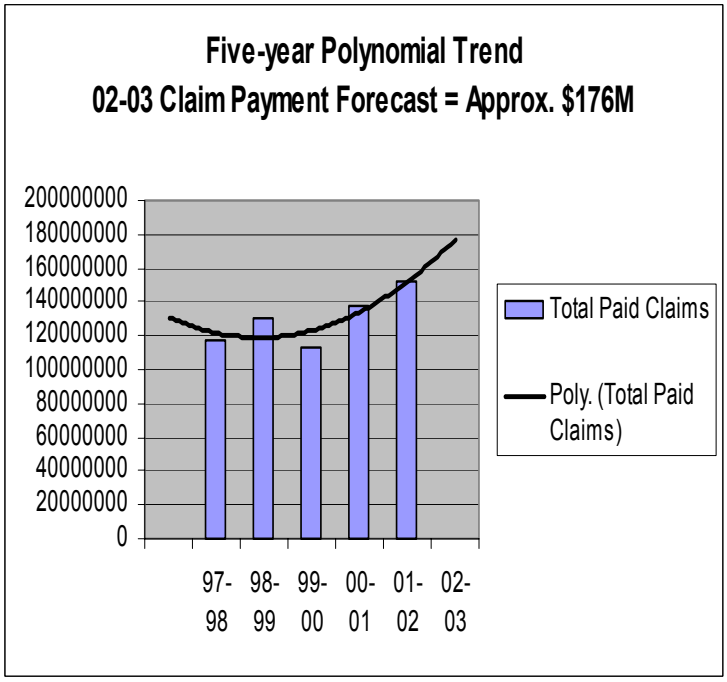


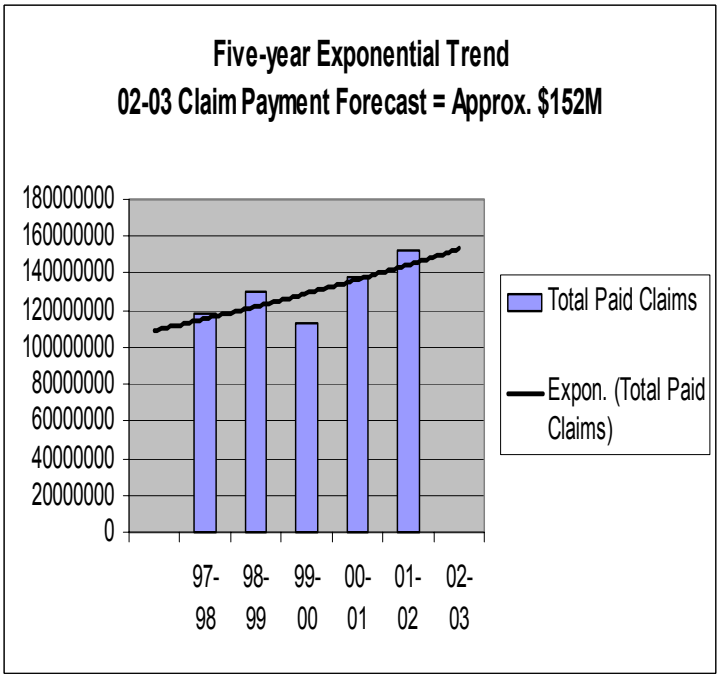



Three-Year Trend Approx $175M
$200,000,000.00
$150,000,000.00
$100,000,000.00
$50,000,000.00
$-
99-00
00-01
01-02
02-03
Total Paid Claims
Linear (Total Paid Claims)


Five-year Linear Trend
02-03 Claim Payment Forecast = Approx. $152M
180000000
160000000
140000000
120000000
100000000
80000000
60000000
40000000
20000000
0
97-98
98-99
99-00
00-01
01-02
02-03
Total Paid Claims
Linear (Total Paid Claims)


Five-year Logarithmic Trend
02-03 Claim Payment Forecast = Approx. $146M
160000000
140000000
120000000
100000000
80000000
60000000
40000000
20000000
0
97-98
98-99
99-00
00-01
01-02
02-03
Total Paid Claims
Log. (Total Paid Claims)

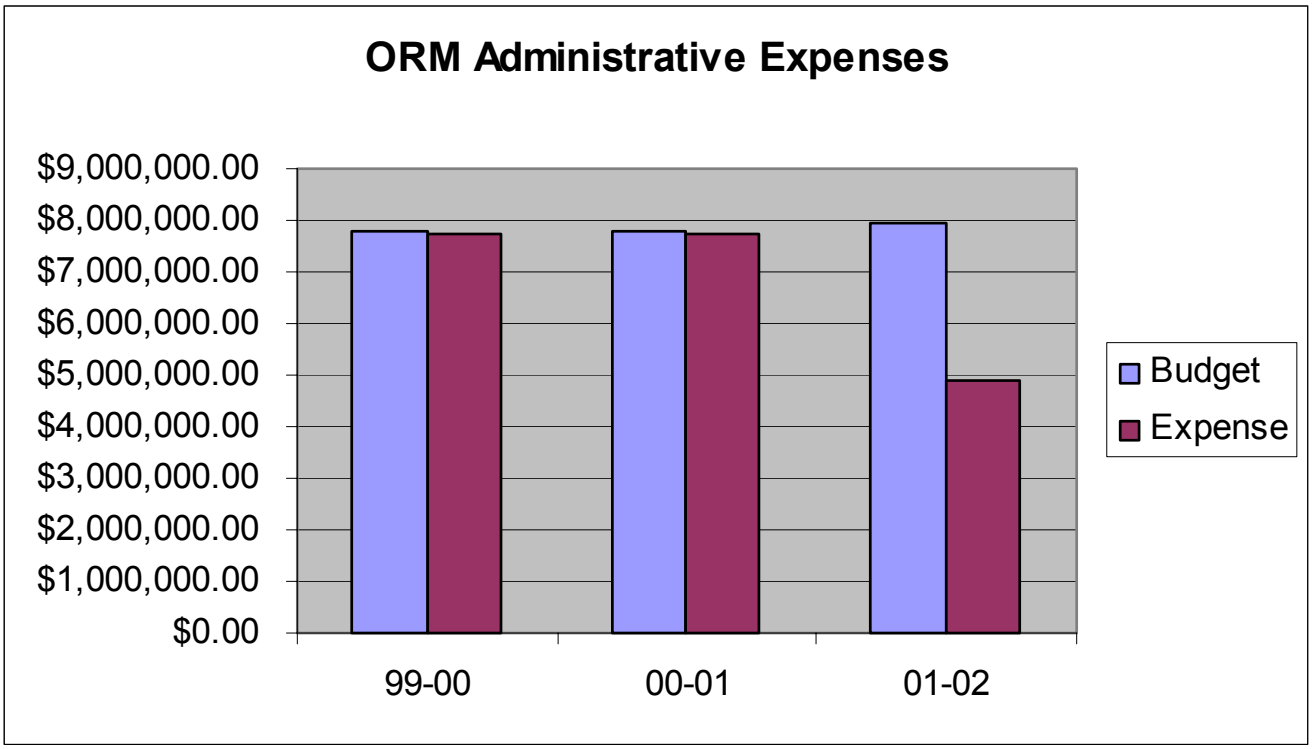

Five-year Polynomial Trend
02-03 Claim Payment Forecast = Approx. $176M
200000000
180000000
160000000
140000000
120000000
100000000
80000000
60000000
40000000
20000000
0
97-98
98-99
99-00
00-01
01-02
02-03
Total Paid Claims
Poly. (Total Paid Claims)



Claim Payment Trend

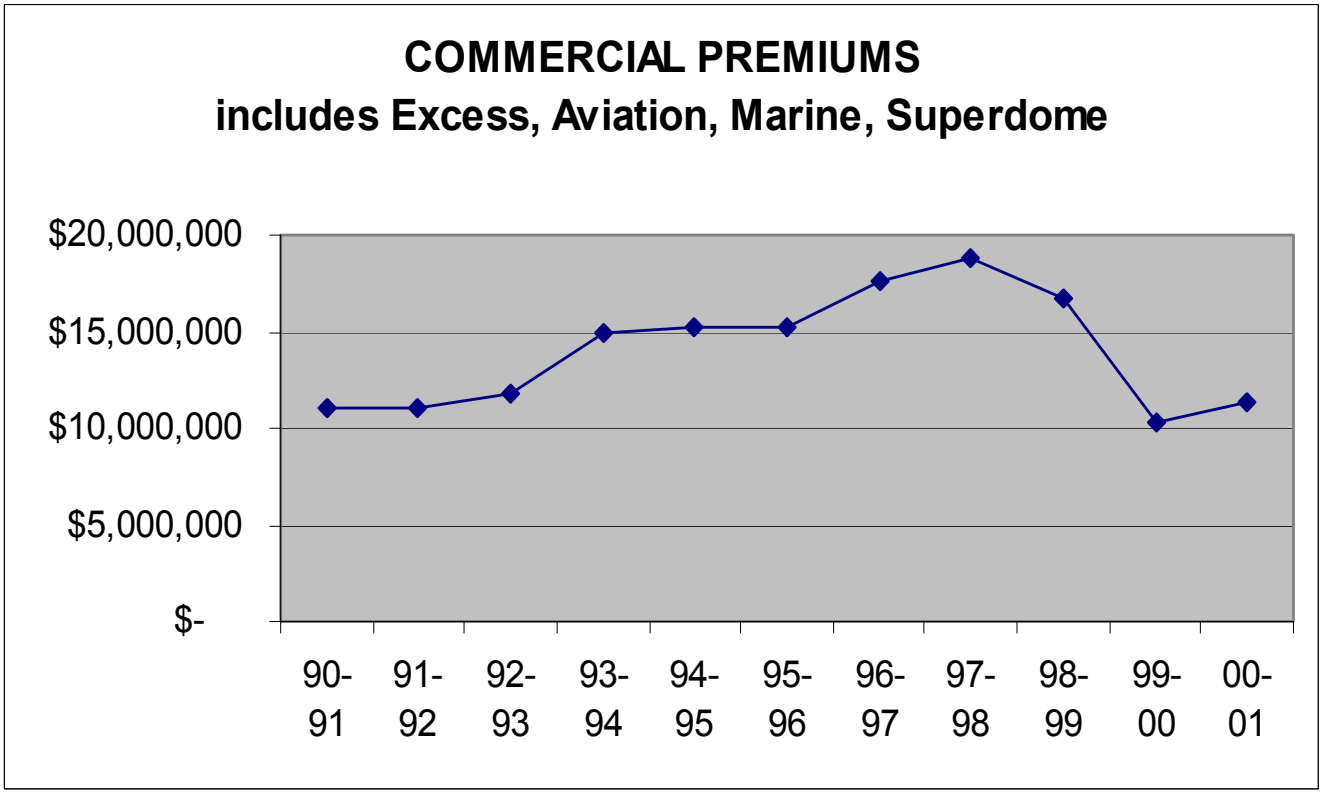
Four Method Average	
Linear	152
Logarithmic	146
Polynomial	176
Exponential	152
Median	152

The Office of Risk Management's Administration Budget is based on the amounts budgeted and spent in the current and two prior fiscal years.



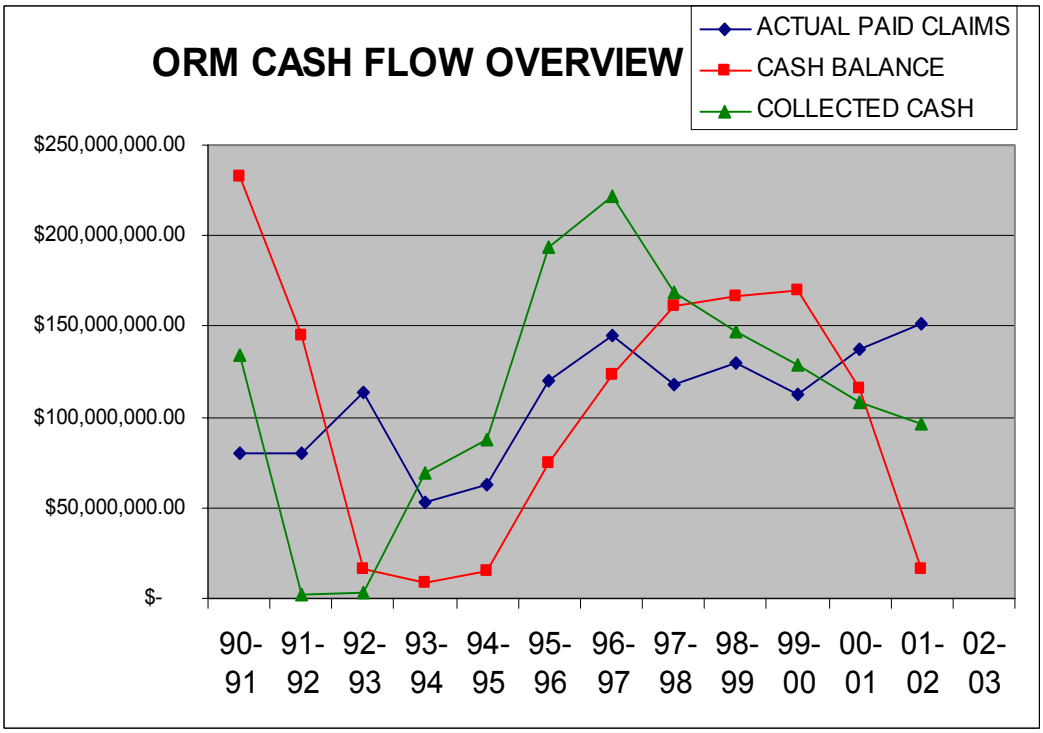
	99-00	00-01	01-02
Budget	$7,800,199.00	$7,763,560.00	$7,923,656.00
Expense	$7,754,849.67	$7,737,070.94	$4,914,538.74

The Commercial Insurance Cash need is an estimate. Actual costs will not be known before all proposals for coverage have been received.

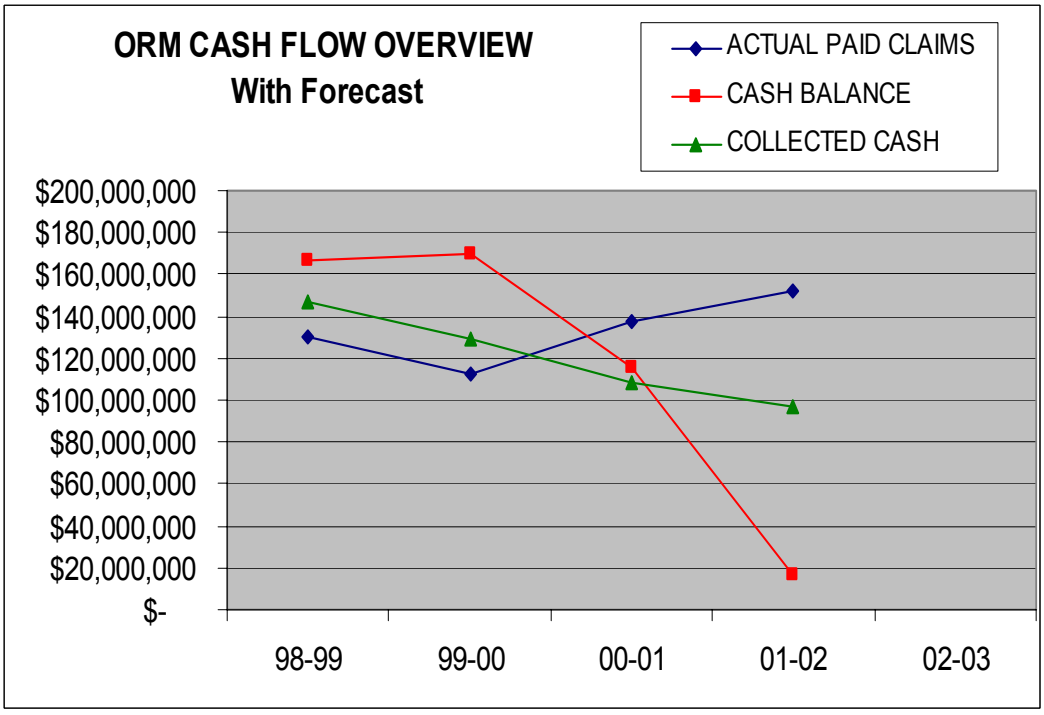


Almost all Commercial Coverages are subject to repricing at 7/1/2002. Considering current market conditions, $20,000,000 would be a conservative estimate for cash needed to pay premium in 02-03.

The 2-Year Cash Reserve is simply a doubling of the amount of cash needed for the forecast period. It is roughly the amount of cash the Office of Risk Management would need to continue operating for a two-year period, in the event of statewide economic crises. The Office of Risk Management went practically unfunded for a two-year period in FY92 and FY93 as illustrated in the chart below. Once the previous Cash Reserve was depleted, some claim payments had to be postponed until additional funding was made available. This led to an increase in penalties



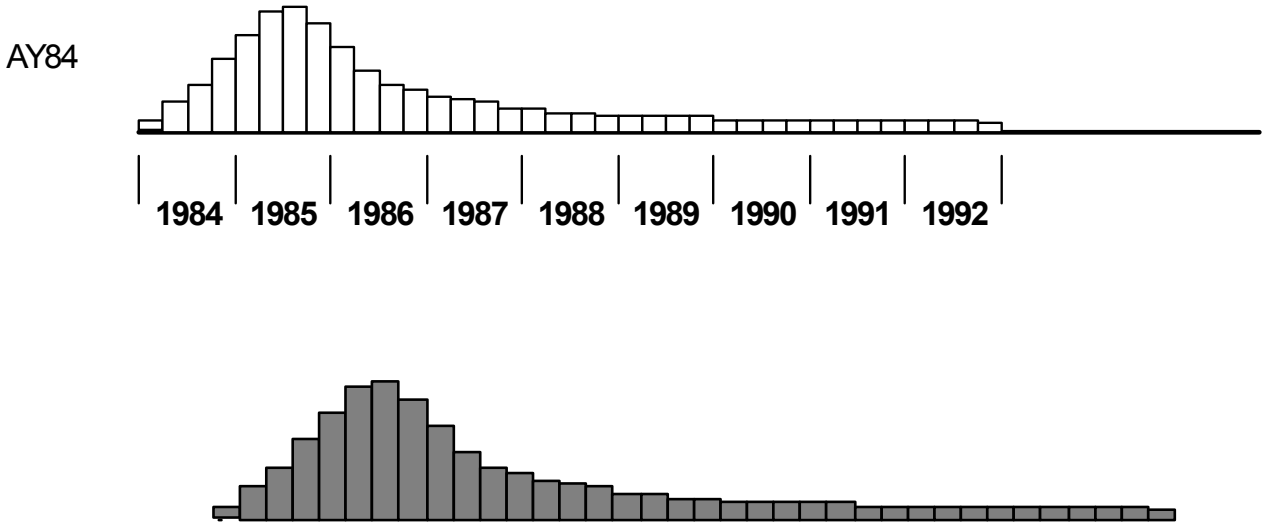
The Office of Risk Management is facing a similar situation as the 02-03 fiscal year approaches. The following chart extends the Office of Risk Management Cash Flow Overview to show the current claim payment and funding projections. It is very important to point out the need to make adequate funding available for continuing operations and provide for the rebuilding of a suitable cash reserve.



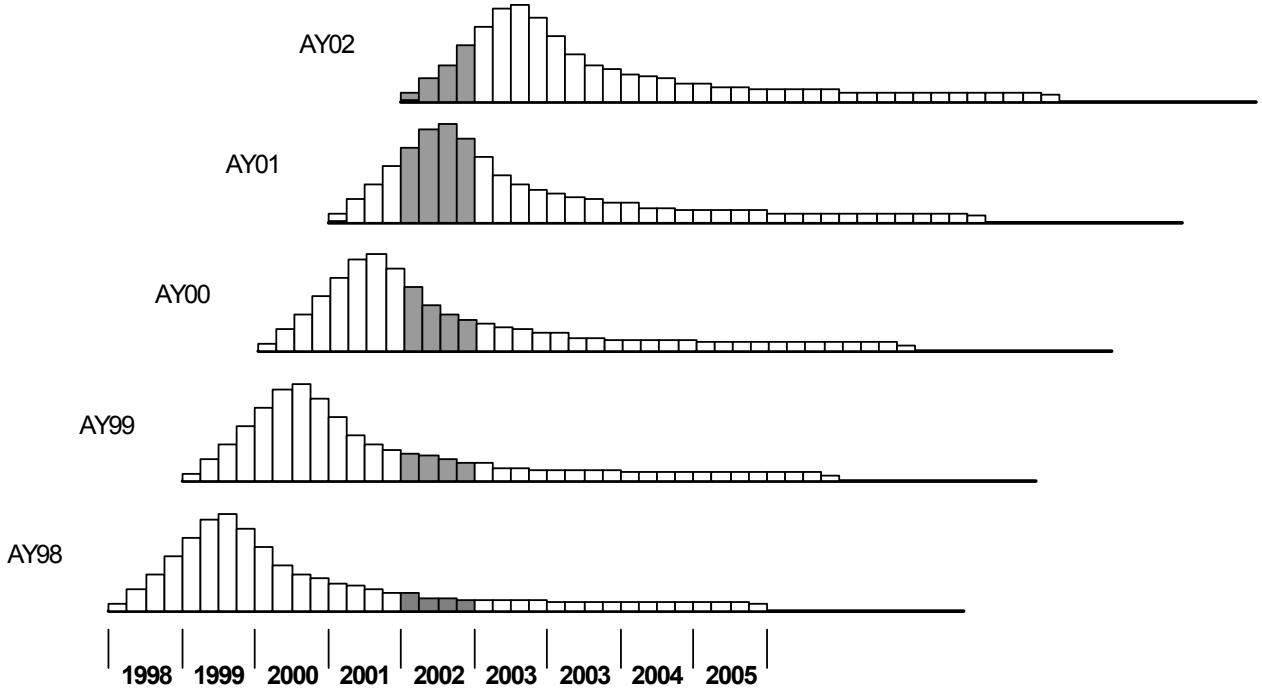
CLAIM PAYMENT CASH NEED	$ 152 M
OFFICE ADMINISTRATION	$ + 8 M
COMMERCIAL INSURANCE	$ + 20 M
CASH NEED FOR FY 02-03	$ 180 M
ANTICIPATED FUNDING	$ - 110 M
CASH GAP	$ 70 M

In addition, the Office of Risk Management should have funds available to take advantage of aged claim closing opportunities when they arise.

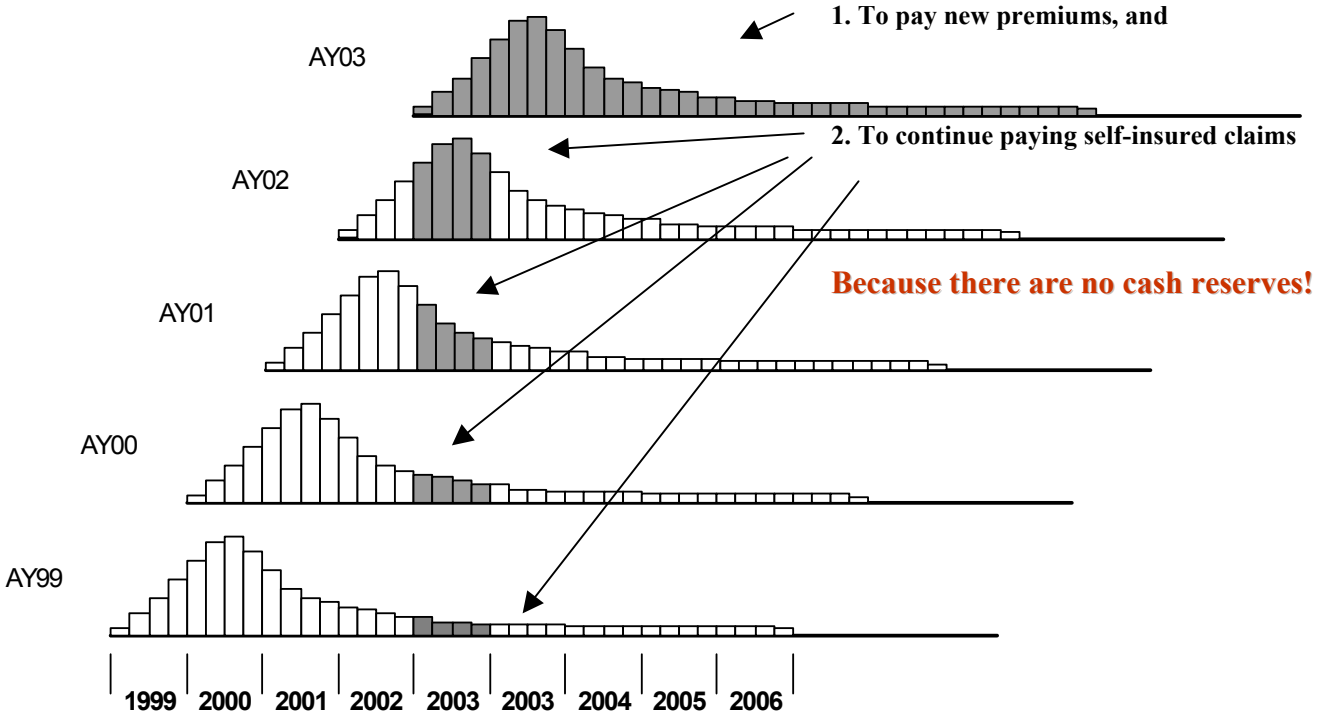
"Premium" includes reserve funds to make future payments on claims occurring during the accident year.



"Claim Payment Cash Need" is the amount of money needed to make payments on all claims occurring in the accident year and all prior accident year, with no reserves for future payments.



Going to commercial markets now would require more short-term cash.



Loss Prevention Special Projects are recommended and explained in the Loss Prevention Assessment. A summary of budgetary needs associated with these initiatives is as follows:

Recommendation	Description	Amount
1	Road Hazard Committee Budget	$ 200,000
2	Medical Malpractice LP Assessment	$ 50,000
5	Cause-of-Loss Targets	$ 200,000
8	Automated Safety Management System	$ 650,000
13	Safety Incentives	$ 270,000
	Total Special Loss Prevention	**$ 1,370,000**

FUTURE YEAR BUDGETING

The Office of Risk Management Budget should be organized into the following categories:

- Self-insured Claim Payment Budget
- Aged-Claim Closing Budget
- Commercial Premium Budget
- Excess Premium Budget
- Claim Payment Reserve Balance
- Administrative Expenses

Self-insured Claim Payment Budget – this would cover anticipated self-insured claim payments to be made during the fiscal year on claims occurring on or after 7/1/2003. Future claims can be handled more effectively by reorganizing the claim management effort, but the effectiveness of any new approach on old claims is limited by the history of the individual claims and how they were handled prior to the implementation. This budget should be expected to grow in the first few years of this organizing effort, then become stable.

Aged-Claim Closing Budget – this money would be needed to make fiscal year claim payments within the self-insured layer on claims occurring before 7/1/2003. There may be a large number of existing claims that could be closed with the implementation of an aggressive action plan. The effectiveness of such an action plan will depend largely on the availability of funds to make settlements. If funds are not simultaneously available to handle new claims in a more effective fashion, then the effort to improve the overall situation will be hampered. In future years, it should be possible to reduce the Aged-Claim closing

fund needs at a faster rate than the growth of the Self-Insured Claim Payment Budget. Ultimately, the Office of Risk Management should expect the Claim Payment Budget to stabilize while the Aged-Claim closing fund continues to dwindle.

Commercial Premium Budget – this will cover the cost of first-dollar insurance policies where self-insurance is not used. Included will be the Aviation and Marine Liability Policies and the Superdome polices for Workers' Compensation and General Liability.

Excess Premium Budget – this will cover the cost of premiums to be paid for layers of coverage above the self-insured limits.

The Administrative Expenses Budget – this would be used to pay all Office of Risk Management operational expenses including unallocated loss adjustment expense. The Administrative Expenses should be detailed for the Underwriting and Loss Prevention operations and managers in those areas should participate in the process. Interviews with managers in those units revealed that they have not operated on a formal budget for two or three years.

Claim Payment Reserve Balance – reserves should be allocated for future claim payment obligations on the self-insured layer to make sure funds are available to continue paying claims in the event of a catastrophic occurrence or an overall budget crises. The state should maintain a position of taking advantage of settlement opportunities when those opportunities are in the state's best interest. At least two year's worth of anticipated operating expenses should be banked to insure cash available in a budget crises situation. A study of possible catastrophic impacts should be made to determine an appropriate level of reserves for such an event.

AGENCY DEDUCTIBLES

The use of deductibles should be considered as a part of the Cost of Risk Allocation effort. The impact of deductibles would be three-fold. First, the allocation of the deductible amount would be a most equitable means of allocating the lowest levels of the self-insurance coverage among the agencies.

Second, agency managers being faced with deductible billings on a regular basis are likely to have a greater interest in safety management than the current practice imposes. With the exception of the Premium Credits for Audits (see Loss Prevention), the consequences of poor safety management behavior are too far removed, in time, to be effective. In the current allocation system, Cost of Risk Allocation is based on a five-year claim experience that is one year removed from the subject fiscal year. Without deductibles, any improvement in the claim experience of an individual agency will take a matter of years to effect an agency's Cost of Risk Allocation Budget. With deductibles, part of the improvement in safety management practice can be realized by the agency right away.

Third, a listing of claims driving the deductible billing (when attached to the deductible billing) is likely to cause an increase in the agency managers' interest in claim details such as cause-of-loss, and in his interest in working with the claim adjusters to mitigating claims arising in his agency. A recommended deductible billing format follows on the next page.

RECOMMENDED DEDUCTIBLE BILLING FORMAT

Agency Name:						**Invoice No.:**	
Agency Code:						**Invoice Date:**	
						Due Date:	
				Amount Paid	**Deductible**	**Prior Invoice**	**New Invoice**
Coverage Line	**Date of Claim**	**Claimant Name**	**Claim Type**	**To Date**	**Amount**	**Amounts**	**Amount**
Workers' Comp					**$ 5,000**		
Work Comp	mm/dd/yy	Doe, John	Medical	$ 33.00	$ 33.00	$ -	$ 33.00
Work Comp	mm/dd/yy	Doe, Jane	Med & Ind	$ 722.16	$ 722.16	$ 410.48	$ 311.68
Work Comp	mm/dd/yy	Deer, Sam	Med & Ind	$ 17,662.09	$5,000.00	$ 5,000.00	$ -
Total Work Comp				$ 18,417.25	$5,755.16	$ 5,410.48	$ 344.68
Auto Liability					**$ 5,000**		
Auto Liability	mm/dd/yy	Public, Paul	Bodily Inj	$ 1,705.00	$1,705.00	$ -	$ 1,705.00
Total Auto Liability				$ 1,705.00	$1,705.00	$ -	$ 1,705.00
							Amount Due
		Invoice Totals:		$ 20,122.25	$7,460.16	$ 5,410.48	$ 2,049.68

To facilitate deductible billings, an **Agency Deductible Budget** will be needed. This budget should be assigned to the individual agencies. Office of Risk Management should bill each agency to collect deductible reimbursements as claim payments are made. The estimates should be actuarially based for claims occurring after 7/1/2003.

A **Deductible Claim Payment Fund** should also be established. This money will be needed to cover the flow of cash between the time Office of Risk Management pays claims and receipt of deductible reimbursements from the agencies.

The organization of the budget, if deductibles are used, should be as follows:

1. Self-insured Claim Payment Budget
2. Aged-Claim Closing Budget
3. Commercial Premium Budget
4. Excess Premium Budget
5. Claim Payment Reserve Balance
6. Administrative Expenses

7. Agency Deductible Budget

8. Deductible Claim Payment Fund

"PREMIUM" ALLOCATION

This allocation process is driven by at least four basic issues:

1. Federal Requirement - OMB A-87 calls for an equitable allocation of risk-related expenses

2. State Requirement - LA R.S. 39:1536 requires premium assessment based on loss experience and exposure

3. Sharing of Risk - The allocation protects individual operating units from large losses within the self-insured layers of coverage.

4. Good business management - Operational efficiency and effectiveness depend upon sound cost allocation.

The Office of Risk Management has an equitable formula to develop recommendations for the allocation of risk-related costs among the various agencies. Only one adjustment is recommended. The actual allocations, however, have been directed by the OPB, and have, at times, varied greatly from the Office of Risk Management recommendations. The Office of Risk Management billings reflect the OPB directions. No attempt was made to analyze the OPB directives, only the Office of Risk Management recommendations.

The DOTD Office of Engineering should be divided for the purpose of calculating the cost of risk allocation. If it is necessary to bill the Office of Engineering as a single unit, the allocated costs can be easily summed after the calculation is made. The inequity of the existing method is explained under "Workers' Compensation Experience Determination" below.

THE ALLOCATION PROCESS

Steps to allocate auto liability premium and the workers' compensation premium for the billing period of 07/01/01 – 06/30/02 were reviewed. First, "premium" is not the right term to describe allocations for the state's self-insurance program. In our definition, "premium" is the amount of money needed to fund the fiscal year operational expenses and all future claim payment obligations associated with a policy-year.

For the self-insured portion of the state's risk management program, premium has not been funded in recent years. What has been allocated is an estimate of the amount of cash needed to cover fiscal year claim payment expenditures for self-insured claims arising out of the fiscal year and all prior fiscal years.

What follows is a description of the way the Office of Risk Management allocated the self-insured

workers' compensation and automobile liability claim payment cash needs for the current fiscal year, 07/01/2001 – 07/01/2002.

WORKERS' COMPENSATION BASIC FORMULA

The self-insured workers' compensation allocation for each agency was calculated within *Corporate Systems* by this formula:

20% x Statewide Cash Need for Workers' comp x Agency Exposure / Statewide Exposure

+

80% x Statewide Cash Need for Workers' Comp x Agency Experience / Statewide Experience

STATEWIDE CASH NEED DETERMINATION

The fiscal year statewide cash need for all self-insured lines was forecast by averaging the claim payments recorded during the four years beginning 7/1/96. The cash need for the workers' compensation line was calculated by averaging four preliminary estimates described to us as follows:

- First, the total cash need forecast was allocated by line based on the prior year loss and ALAE expenditures for each line.
- Second, the total cash need was allocated by line based on the prior year allocation.
- Third, the actuarial premium need for workers' compensation ($74,435,000) was compared to the total actuarial premium need ($399,332,000) and the ratio was applied to the total cash need for all lines.
- Fourth, the total cash need amount was compared to the actuarial premium need calculated for all lines and the resulting ratio was applied to the actuarial premium need for the workers' compensation line.
- The calculated average was rounded to the nearest $1,000.

WORKERS' COMPENSATION EXPOSURE (PAYROLL) DETERMINATION

The Office of Risk Management obtained most of the agency payroll records from the *ISIS* system. These data were downloaded to CORA Support. (Note: *CORA Support* is a custom application designed specially for the Office of Risk Management.). For the 2001-2002 allocation period, payroll records for FY 99-00 were used. Some agencies, which were not using *ISIS*, reported payrolls in paper form or via email.

WORKERS' COMPENSATION EXPERIENCE DETERMINATION

Once the exposure information for quarter ending 06/30/2000 was received, loaded, adjusted and confirmed, the Office of Risk Management requested a duplicate database be created (by *Corporate*

Systems) to freeze claim and exposure records. The exposure determination was then based on the claim data in this duplicate, frozen database.

For the 07/01/2001 – 07/01/2002 allocation period, claim data from the 07/01/1995 – 070/1/2000 period was used. A loss limitation was applied to the individual claim values for the workers' compensation line. The limitation was calculated for each billing unit by the following formula and subjected to a $15,000 minimum:

(Billing Unit Losses / Statewide Losses) x $1,000,000 = Loss Limitation

The exposure period and loss limitation figures were user-selected by Office of Risk Management staff and explained as being the same parameters used in years past. While the use of such parameters as a means of spreading risk within the self-insured layer is understood, this assessment did seek to ascertain the original reasoning behind these particular selections.

On average, 60.5% of the state's actual workers' compensation losses were within the loss limitations and were included in the experience allocation formula. However, for a number of small agencies, with small losses, the limitation did not have any effect and all of the losses (100%) were counted in the allocations. Most of the larger agencies had adjusted losses in the range of 50% to 70% of actual total losses. This summary appears in the chart below.

Experience Allocation Total Loss and Adjusted Loss Comparison

DEPARTMENT	Total Losses	Adjusted Losses	
10 EXECUTIVE	$ 1,530,476	$ 841,381	55.0%
400 DIVISION OF ADMINISTRATION	$ 780,682	$ 503,396	64.5%
500 DEPT. TRANSPORTATION & DEVELOPMENT	$ 12,147,520	$ 11,072,405	91.1%
900 LSUMC HEALTH CARE SVS	$ 10,286,575	$ 5,595,111	54.4%
1000 DEPT. HEALTH & HOSPITALS	$ 29,741,167	$ 18,938,547	63.7%
1800 DEPT. SOCIAL SERVICES	$ 2,375,113	$ 1,384,289	58.3%
2000 DEPT. CORRECTIONS	$ 17,257,115	$ 9,042,676	52.4%
2200 DEPT. PUBLIC SAFETY	$ 5,110,515	$ 2,286,866	44.7%
2300 DEPT. NATURAL RESOURCES	$ 395,799	$ 107,499	27.2%
2400 DEPT. ENVIRONMENTAL QUALITY	$ 200,010	$ 133,357	66.7%
2500 DEPT. ECONOMIC DEVELOPMENT	$ 36,592	$ 36,592	100.0%
2600 DEPT. LABOR	$ 684,571	$ 393,624	57.5%
2800 DEPT. WILDLIFE & FISHERIES	$ 1,691,836	$ 690,961	40.8%
2900 DEPT. REVENUE	$ 428,745	$ 234,020	54.6%
3000 DEPT. CIVIL SERVICE	$ 8,426	$ 8,426	100.0%
3100 DEPT. CULTURE, REC, TOURISM	$ 1,125,569	$ 488,069	43.4%

3200	LIEUTENANT GOV	$ 1,000	$ 1,000	100.0%
3300	DEPT OF STATE	$ 43,684	$ 31,975	73.2%
3400	DEPT OF JUSTICE	$ 222,321	$ 104,082	46.8%
3500	DEPT OF ELECTIONS	$ 11,651	$ 11,651	100.0%
3600	DEPT OF TREASURY	$ 12,268	$ 12,268	100.0%
3700	DEPT. AGRICULTURE & FORESTRY	$ 1,935,590	$ 1,027,270	53.1%
4000	DEPT. OF INSURANCE	$ 107,324	$ 84,405	78.6%
4100	DEPT. OF EDUCATION	$ 1,273,730	$ 420,380	33.0%
4300	DEPT. OF PUBLIC SERVICE	$ 956	$ 956	100.0%
4400	LSU SYSTEM	$ 11,072,523	$ 7,256,794	65.5%
4600	SOUTHERN UNIV SYSTEM	$ 1,456,580	$ 940,914	64.6%
4800	TRUSTEES SYSTEM OF UNIVERSITIES	$ 7,622,996	$ 3,575,679	46.9%
5800	SPECIAL SCHOOLS & EDUCATION AGENCY	$ 1,101,545	$ 589,609	53.5%
6000	LA COMMUNITY & TECH COLLEGES	$ 1,007,094	$ 628,988	62.5%
7000	EMPLOYEE BENEFIT SYSTEM	$ 62,400	$ 45,678	73.2%
7200	MISC BOARDS AND COMMISSIONS	$ 508,559	$ 208,175	40.9%
7600	LEGISLATURE	$ 20,470	$ 20,470	100.0%
7700	JUDICIARY	$ 107,842	$ 97,842	90.7%
	STATEWIDE	**$ 110,369,244**	**$ 66,815,355**	**60.5%**

Of particular note was the relatively high loss limitation used in the adjustment of losses for the DOTD Engineering billing unit. The loss limitation was $109,000 and the adjusted losses for that billing unit were 91.9% of the actual losses. This can be directly related to the size of DOTD Engineering as a billing unit. Had DOTD been broken down into more numerous billing units (as was noted among other large agencies), the loss limitations and the adjusted losses used in the allocation formulas would have been smaller, and the ultimate experience allocation for DOTD's budget needs would have been less. If DOTD's limitations were such that the adjusted losses would have been 60.5% of actual total losses (as was the state average), approximately $1.6 million would have been allocated among the other agencies, and DOTD's experience allocation for workers' compensation would have been less by that amount.

A written account detailing an earlier analysis of this issue was located but the documents found were not dated, and the author and recipient were not identified. It does not appear that any action was ever taken as a result of the earlier findings.

The Office of Risk Management users specified the experience-to-exposure ratio, 80/20 for the workers' compensation line. The selections were copied from prior years but no means of ascertaining the original reasoning behind them was identified, except that *Corporate Systems* had used some for demonstration purposes. Information from *Corporate Systems* staff confirmed there are no standards, but they did indicate the ratios used by the Office of Risk Management for workers' compensation, general liability, auto liability, and auto physical damage were consistent with general practice among their contacts.

AUTO LIABILITY BASIC FORMULA

The self-insured auto liability allocation for each agency was calculated within *Corporate Systems* by this formula:

30% x Statewide Cash Need for Auto Liability x Agency Exposure / Statewide Exposure

+

70% x Statewide Cash Need for Auto Liability x Agency Experience / Statewide Experience

STATEWIDE CASH NEED DETERMINATION

The fiscal year statewide cash need for all self-insured lines was forecast by averaging the claim payments recorded during the four years beginning 7/1/96. The cash need for the auto liability line was calculated by averaging four preliminary estimates described to us as follows:

First, the total cash need forecast was allocated by line based on the prior year loss and ALAE expenditures for each line.

Second, the total cash need was allocated by line based on the prior year allocation.

Third, the actuarial premium need for auto liability ($11,063,000) was compared to the total actuarial premium need ($399,332,000) and the ratio was applied to the total cash need for all lines. (The method for calculating the actuarial premium will be studied in greater detail during the next phase of the project.)

Fourth, the total cash need amount was compared to the actuarial premium need calculated for all lines and the resulting ratio was applied to the actuarial premium need for the auto liability line.

The calculated average was rounded to the nearest $1,000.

AUTO LIABILITY EXPOSURE (MILEAGE) DETERMINATION

Between 07/01/99 and 06/30/00, Office of Risk Management mailed out a request to each agency to obtain miles driven during the quarters. The request forms were filled out by the agencies and returned to the Office of Risk Management and the data was manually entered into *CORA Support.* The *CORA Support* system multiplied the total private vehicle mileage by 5% and added the result to the public vehicle mileage to arrive at a total vehicle miles for each quarter.

CORA Support mileage data for each agency was loaded up to *Corporate Systems* after all quarterly reports for all agencies had been received. *Corporate systems* personnel compared totals reported by the Office of Risk Management to the *Corporate Systems* totals found in the system after the upload. The Office of Risk Management was responsible for identifying discrepancies and communicating correction instructions to *Corporate Systems* personnel via email.

AUTO LIABILITY EXPERIENCE DETERMINATION

Once the information for quarter ending 06/30/2000 was received, loaded, adjusted and confirmed, Office of Risk Management requested a duplicate database be created (by Corporate Systems) to freeze claim and exposure records. The exposure determination was then based on the claim data in this duplicate, frozen database.

For the 07/01/2001 – 07/01/2002 allocation period, claim data from the 07/01/1995 – 07/01/2000 period was used. A loss limitation was applied to the individual claim values for the workers' compensation line. The limitation was calculated for each billing unit by the following formula:

(Billing Unit Losses / Statewide Losses) x $1,000,000 = Loss Limitation

The result was subject to a $15,000 minimum loss limitation.

The exposure period and loss limitation figures were user-selected by Office of Risk Management staff and explained as being the same parameters used in years past.

The DOTD auto liability experience allocation was affected by the size of the DOTD Engineering billing unit as was the case with the workers' compensation line. Although an estimate of the allocations among the agencies to show what it would have been had DOTD been broken down into more numerous billing units was not done, the result of that analysis would be expected to be similar to the result described for workers' compensation above.

The experience to exposure ratio, 70/30 for the auto liability line, was specified by the Office of Risk Management user. Again, these selections were copied from prior years. Information from corporate systems staff confirmed there are no standards, but did indicate the ratios used by the Office of Risk Management for workers' compensation, general liability, auto liability, and auto physical damage were consistent with general practice among their contacts.

PLAN REPORT

Once all of the user entries for all lines were completed, Office of Risk Management staff issued a request to have *Corporate Systems* personnel run the report job (i.e., DB210 job in the duplicate database). The result was the Cost of Risk Allocation, Plan T report that had been maintained in the Office of Risk Management offices.

OTHER LINES OF INSURANCE

Allocation for the other self-insured lines of insurance appears to have been calculated in the same fashion as the workers' compensation and auto liability lines. The only differences noted were in the exposure / experience ratios and the basis for exposure. A summary of the ratios and basis by line is listed below:

Coverage Line	Exposure Base	Experience/Exposure Ratio
Workers Compensation Statutory	Regular Payroll	80/20
Workers Compensation Maritime	Maritime Payroll	45/55

Comprehensive General Tort Liability	Total Compensation	60/40
Automobile Liability	Total Mileage	70/30
Auto Physical Damage	Licensed Vehicles	70/30
Boiler & Machinery	Boiler & Machinery	35/65
Building & Property	Property Values	20/80
Bonds	Bond Units	50/50
Crime Self-Insured	Crime Units	30/70
Personal Injury Liability	Total Compensation	80/20
Medical Malpractice	Med Mal Contacts	60/40
Road Bridge, Dam & Tunnel	Road & Bridge	100/00
Misc. Tort (NOC)	Regular Payroll	60/40

DATA QUALITY

The exposure data used to allocate premium and needed for the calculation of loss costs as recommended in Loss Prevention section above, are derived from a variety of sources, including direct reporting from agency units through paper mail or data entry on the Office of Risk Management website. Assessment interviews revealed a low level of confidence in this data. The number of licensed vehicles, for example, was questioned, as were the values for movable property. Some difficulty was encountered when attempting to confirm payroll figures. No single repository for statewide data, outside of the *CORA* data records (which were only available in hard copy) could be found. Some of the payroll figures were extracted from the *ISIS* system, but not all. A formal data quality effort should be undertaken to improve the level of confidence in exposure data. A method for validating sources and verifying records should be devised.

POLICIES AND PROCEDURES

The Underwriting Unit has a detailed policy and procedure manual along with an observed high- level of adherence to those policies. The policies were formally generated in 1998 and were authored primarily by the members of the existing staff. Informal updates have occurred from time-to-time. These appear to have been adequate given the high-level of experience and relatively low turnover rate of staff members. However, the process of review and update of these procedures should be formalized and records of changes should be maintained.

The procedures address the issues of policy renewal for the self-insured and commercial excess policies and those policies purchased for first-dollar coverage outside the self-insurance program. Included are procedures for maintaining policy language that provides broad coverage for the state agencies and for modification of language to reflect industry changes or previously unanticipated exposures.

Procedures also address the maintenance of property value data for fixed assets, movable property and buildings under construction; issuance of insurance certificates for the self-insured coverage and obtaining certificates from commercial carriers on behalf of client-agencies. Premium invoicing is part of the underwriting function.
To secure the commercial insurance coverage (excess and non-self-insured first dollar) the underwriters prepare requests for proposal, issue the requests, evaluate the bids and interact with successful bidders to secure the policies. The policy forms and the Request for Proposal (RFP) process will be reviewed in greater detail in the next phase of the project.

CONTINUATION PLAN

Currently, two of the three most Senior Underwriters are eligible for retirement benefits including the current State Risk Underwriting Manager and State Risk Underwriting Supervisor. There appears to be only one junior individual, a State Risk Underwriter 3, who has a broad understanding of the unit and who may be able to take responsibility in the absences of the three senior underwriting staff members. A continuation plan should be developed to maintain a high-level of underwriting expertise in the event of retirement elections.

CONTRACT REVIEW

The Underwriting Unit routinely evaluates insurance-related contract language for state agencies planning to do business with non-state entities. The focus of this activity is to avoid assumption of the risk of others by the state when entering into contractual agreements. The State Risk Underwriting Manager has become recognized outside the Office of Risk Management as a valuable resource in this area and he is called upon regularly for his opinion on these matters. This was confirmed in interviews with the Division of Administration's State Contracts Administrator and Legal Counsel. Additional comments in memorandum were offered by the Director of the DRL

The staff consistently indicated that contract review had become an increasingly significant part of the work done in this unit, particularly during the last four or five years. Staff began tracking the number of contracts reviews in June 2001. There is no formal procedure for this activity.

Some memory of claims paid for assumed risk was mentioned in the interviews but identification of those cases has not been made. Identification and tracking of such claims should be done to measure the effectiveness of this activity and to identify opportunities for improvement if future claims are paid in this area. There was a shared concern in all these interviews that several contracts may be slipping through because there are not enough resources available to review them all.

EQUIVALENT COMMERCIAL PREMIUM

A stated objective of the Office of Risk Management is *"to provide all state agencies with insurance coverage at a price that is less than the equivalent commercial coverage cost."* The Office of Risk Management uses elaborate calculations designed to produce a number equivalent to actual savings of the self-insured program over commercially obtained insurance. This process cannot succeed. In volatile markets that have come to characterize the commercial insurance market, it is impossible to predict with any acceptable range of accuracy what commercial insurance would actually cost. The most exact way to determine the cost of commercial insurance would be to release RFPs for all lines of business. Since the state has neither the funds available to purchase such insurance nor the desire to make such large purchases, this process is unavailable.

A reasonable alternative, and one that would enhance the Office of Risk Management's insurance operations in many ways, would be to issue a Request for Qualifications (RFQ) to the major broker market. If the Officer of Risk Management were to contract with one single broker to handle all insurance placements and to assist in determining the structure of the Office of Risk Management's insurance portfolio, the results would be greatly enhanced. This is provided a solid RFQ is issued and a selection made based upon proven excellence in existing municipal markets. Such a request would ask for credentials in the brokerage market,

experience in servicing largely self-insured entities, experience with placement of primary, excess and reinsurance, references, and the like. This broker could best estimate the cost of various coverages if purchased.

The current insurance placement system is not sophisticated. The bidding process is not controlled allowing the possibility of a single bidder to block most of the competitive market. It does not provide meaningful servicing by a single, dedicated broker yet pays commissions that would normally insure such service. Many brokers are willing to provide this service for no fee if they are allowed to handle the insurance placement. Broker services are obtainable on a consulting basis in cases where the broker is not allowed to participate in the insurance placement.

A detailed examination of the commercial insurance structure would benefit the Office of Risk Management. Retention levels, alternative risk financing techniques, unusual opportunities that might become available, and prediction of expected cash needs over extended periods could be performed by a qualified broker.

COMPANY SELECTION

Large insurance conglomerates may control as many as six different insurance companies, each of which is individually licensed to conduct business within the state. Each of theses companies may have differing rate filings allowing the underwriters to use the low rate filings for the most desirable business (preferred) and the higher rates for others. An accurate measure of equivalent commercial coverage cost would require an accurate guess as to which licensed company a multi-company conglomerate might use.

SCHEDULE RATING

In some insurance lines, underwriters may apply schedule rating credits or debits to rated premiums to reflect better-than-average or worse-than-average risks. As an example, workers' compensation companies commonly file schedule rating plans that allow as much as 25% credit and 25% debit. In practice, it is believed that the eligibility for such credits or debits varies among underwriters and is influenced in large degree by market conditions. An accurate measure of equivalent commercial coverage cost would require an accurate guess as to how much, if any, schedule rating may be applied to insurance policies covering the state's risks.

CONSENT-TO-RATE

In Louisiana, it is possible for insurance companies to deviate from some approved rate filings so long as the policyholder consents to the rates being charged. An accurate measure of equivalent commercial coverage cost would require an accurate guess as to which, if any, companies may be willing to offer pricing outside of filed rate plans and a guess as to how much deviation might be used.

The measurement of this objective requires a considerable effort on the part of the unit manager and may be creating a false sense of success (or failure). Moreover, if it were to be perceived that the commercial markets offered a more cost-effective way to deal with currently self-insured risks, the likelihood of a change is probably small because of the significant cash flow increase that would be needed to pay premium.

During the 1980's Louisiana made a transition from funding self-insured premiums to funding only the estimated fiscal year claim payment obligations in the self-insured lines. In doing so, the state was able to

make use of premium funds that had been previously accumulated. As a result, the outstanding obligations that are not currently funded amount to something on the order of $800,000,000.

It is believed that the only valid way to measure the equivalent commercial coverage cost is to go to the commercial insurance markets and request proposals. But, because there would be a significant short-term cash flow increase required to fund premium, the likelihood of an insurance purchase by the State, in lieu of the current self-insurance programs, would be small. However, without a realistic chance of getting the State's business, commercial underwriters will not be interested in putting forth the effort to respond to a Request for Proposals in a competitive fashion.

PRODUCTIVITY

The Underwriting Unit diligently counts tasks performed in a number of areas on a monthly basis. In addition to contract reviews, the group counts certificates of insurance processed, bids / amendments, policy renewals and premium invoices. A report is prepared for the State Risk Director at the end of each month. It has not been determined how this information is used at the Director level, but it is felt that there should be a resource measure included (available man-hours or person-days) in this exercise so that productivity can be measured per unit resource, not simply in bulk.

MARINE AND AVIATION BILLING

The Underwriting Unit enters Marine and Aviation premiums for agencies having exposure every year. These premiums are received through the commercial bid process and allocated according to the schedule of exposures. Only those agencies with exposures are billed. For the current year, the Underwriting Unit billed all calculated premiums although these premiums were not included in the budget process for this year. Later in the year, the Office of Risk Management received a call from one of the agencies saying they did not have the money to pay. The issue has been submitted to the Office of Planning and Budget (OPB) for guidance and the Office of Risk Management is awaiting a response.

In prior years, the Office of Risk Management has been instructed by OPB to bill some agencies, but not others. In some years, Office of Risk Management was instructed not to bill any agencies for any premiums. The Accounting Unit Head and the Assistant State Risk Director confirmed this. Marine and Aviation was last budgeted and billed in 1998-1999. It was not budgeted or billed in 1999-2000, nor in 2000-2001. At that time, Office of Risk Management decided not to include Marine and Aviation because it was anticipated that OPB would authorize billings for less that the budgeted amounts. It was believed there would be difficulty in equitable distribution of all premiums, and the amount of the Aviation and Marine was not significant relative to the total. The issue would be further complicated by the fact that some agencies were not subject to Marine and Aviation premiums because they had not exposures. Marine and Aviation premiums were left out because including those premiums would have made the allocation process more difficult.

Although the agencies did not budget the money, Office of Risk Management has begun to bill it; however, some agencies have indicated they do not have the budget to pay the premiums.

Loss Prevention Unit

The unit is led by Doris Copeland and is comprised of:

Loss Prevention Supervisors	2
Loss Prevention Officer 2	9
Clerk Chief 1	1
Total Staff	**13**

SUMMARY OF FINDINGS AND RECOMMENDATIONS

The responsibilities of the Loss Prevention Unit are grouped into four categories:

- Audit
- Building Appraisal
- Training
- Investigations

Interviews have been conducted and field interviews/observations were completed with Loss Prevention Officers. The **METHODS** Project Team attended an Agency Audit opening meeting at the Department of Transportation and Development (DOTD) and a closing meeting at the Department of the Treasury. The **METHODS** Project Team participated in an elevator inspection demonstration as well as attended Safety Audits at the DHH Headquarters in Baton Rouge, the DOTD District 07 Field Office in Calcasieu Parish and at the Bridge City Correctional Center for Youth. The team also reviewed reports on thirty-two Accident Investigations and participated in two follow-up calls in the field.

It was determined that unit costs for loss prevention services were comparable to and less than industry benchmarks. The results are summarized below.

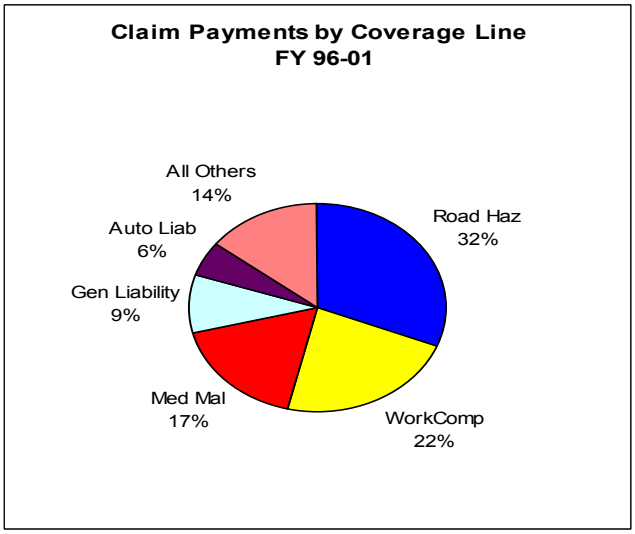
Loss Prevention Cost Bencmarks	ORM LP FY 00-01	Comparison Company 1 CY 2001	Comparison Company 2	Texas ORM	Arkansas ORM
Expenses per unit field staff	$ 86,130	$ 101,723			
Expenses per field man-month	$ 7,330	$ 8,477			
Cost per Report	$ 191	$ 231			
Miles Driven per unit field staff	1249				

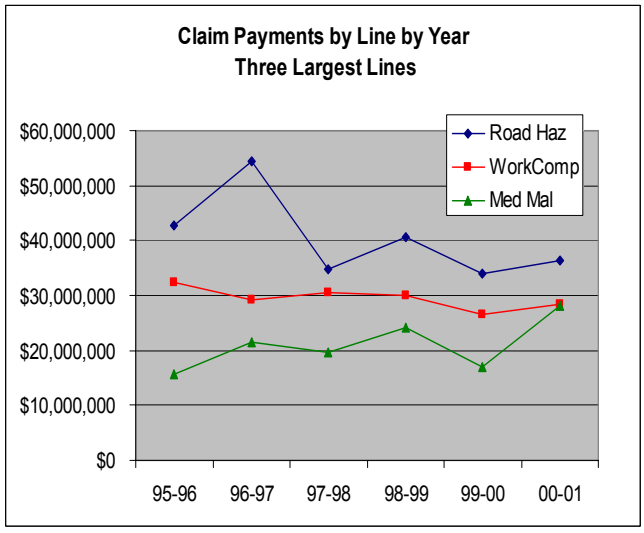
Workers' Compensation is the largest coverage line with exposures in practically all State agencies and is the largest of the coverages addressed by the Loss Prevention Safety Audits. For this reason, the assessment focused on workers' compensation claim and exposure data for most of the analysis of the Office of Risk Management Loss Prevention Unit.

The following subsections summarize the overall findings and recommendations generated as a result of this assessment.

MEDICAL MALPRACTICE AND ROAD HAZARDS

Claim payments in these two self-insured coverage lines have made up almost half of all claim payment expenditures over the past 5 years. This is illustrated in the graph.





Appropriately, the exposures associated with these two lines are not addressed in the Office of Risk Management Safety Audits as illustrated below.

Rank	Coverage Line	Safety Audit	
1	Road Haz	No	32%
2	Work Comp	Yes	22%
3	Med Mal	No	17%
4	Gen Liability	Yes	9%
5	Auto Liability	Yes	6%
		Total No	49%
Rank	**Coverage Line**	**Safety Credit**	
1	Road Haz	No	32%
2	Work Comp	Yes	22%
3	Med Mal	No	17%
4	Gen Liability	Yes	9%
5	Auto Liability	Yes	6%
		Total No	49%

The Road Hazard exposures are unique to the Department of Transportation and Development (DOTD) operations and therefore should not be part of an evaluation of other agencies. Medical malpractice is only common to a limited number of agencies and loss prevention for these exposures is highly specialized. Medical malpractice loss prevention is not something the existing Office of Risk Management staff should be expected to manage. It does not appear that there is any concerted effort to reduce the losses driving this significant category of payment. An assessment by professionals qualified in medical malpractice risk management should be undertaken.

COST-BENEFIT ANALYSIS AND CLIENT-LEVEL SUPPORT

The **METHODS** Project Team did not found any cost-benefit analysis being performed for the general, overall loss prevention programs. In fact, the unit manager has not been included in the budgeting process in a meaningful way for at least two years. At the time of the interview, the unit manager had no knowledge of actual expenses with which to begin such an analysis. The only benefit measures known in the unit were the *Corporate System "Scoreboard"* report and the 5.00-Plus accrual rate listings. These formats are inadequate to measure benefits of loss prevention interventions.

The initiatives and the loss cost derivations described below are offered as a model for cost-benefit calculations.

SAMPLE ROI CALCULATION FOR TARGETED LOSS PREVENTION SPENDING

Department of Health & Hospitals
Statewide Workers Compensation Claims
For FY 1999, 2000, 2001
Statewide Loss Data as of 9/30/01*

Rank	Incurred Amount	Cause Code	Description	Three-Year Total Number of Claims	Average Amount per Claim	Development	Developed Average
1	$ 5,544,409	2A	Strain by lifting, twisting	1027	$ 5,399	1.5	$ 8,098
2	$ 2,099,982	1C	Struck by patient/employee	727	$ 2,889	1.5	$ 4,333
3	$ 1,736,373	3A	Slip and Fall on Foreign object	330	$ 5,262	1.5	$ 7,893
4	$ 1,377,957	9A	Tripping	175	$ 7,874	1.5	$ 11,811
5	$ 624,636	AP	Miscellaneous / NOC	41	$ 15,235	1.5	$ 22,853

*From DHH self-study by Bill Perkins with data provided by Dan Martin, ORM Statistical Unit.

Location 1680 - Pinecrest Developmental

Rank	Incurred Amount	Cause Code	Description	Three-Year Total Number of Claims	Average Amount per Claim	Development	Developed Average
1	$ 1,824,642	2A	Strain by lifting, twisting	380	$ 4,802	1.5	$ 7,203

Sample Calculation

If an intervention at Pinecrest reduced the number of "Strain" injuries by 25%, the savings would be approximately $684,000 over three years.

Base Count	Target Reduction	Reduction Count	Cost per Claim	Savings	Annual Savings
380	25%	95	$ 7,203	$ 684,241	$ 228,080

If the intervention at Pinecrest costs $50,000 per year, the return on such an investment would be greater than 400%.

Annual Savings	Annual Cost	Return
$ 228,080	$ 50,000	356%

The **METHODS** Project Team did not find any valid measurement of results at the client level. Proactive planning on behalf of the client-agencies appeared to be focused, primarily on preparation for passing the Safety Audits and there seemed to be a genuine sense of service among the staff. An attempt was made to analyze the cost-benefit for Loss Prevention action at the DHH, but DHH personnel, not Office of Risk Management, initiated the action. The report compiled by DHH provides a very good example of what the customer needs and this should be used as a model for planning and measurement at the client level. The following chart shows an extension of this data and how it should be used for calculating Return on Investment.

ROI Calculation for Recommended Loss Prevention Initiatives

Automated Safety Management System	$ 650,000
Annual Safety Incentives Expense	$ 1,620,000

Target Reduction in Statewide Loss Cost = 15%

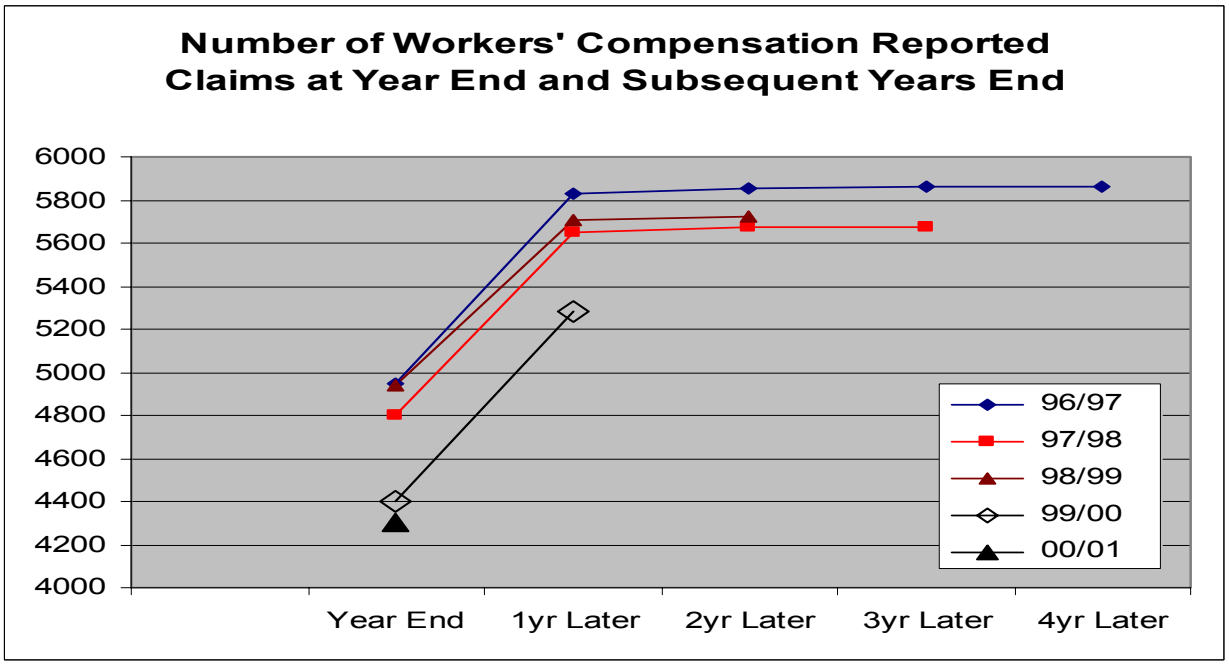
Statewide Payroll	X (Basline Loss Cost - Target Loss Cost)	
$ 3,200,000,000	X (0.657 - .558) Dollars per $100 payroll	
	= $ 3,168,000	

	System Cost	Incentive Cost	Savings
1st Year	$ 650,000	$ 540,000	0
2nd Year		$ 1,620,000	$ 3,168,000
3rd Year		$ 1,620,000	$ 3,168,000
Total	$ 650,000	$ 3,780,000	$ 6,336,000

Total Savings	$ 6,336,000
Total Cost	$ 4,430,000
ROI	43%

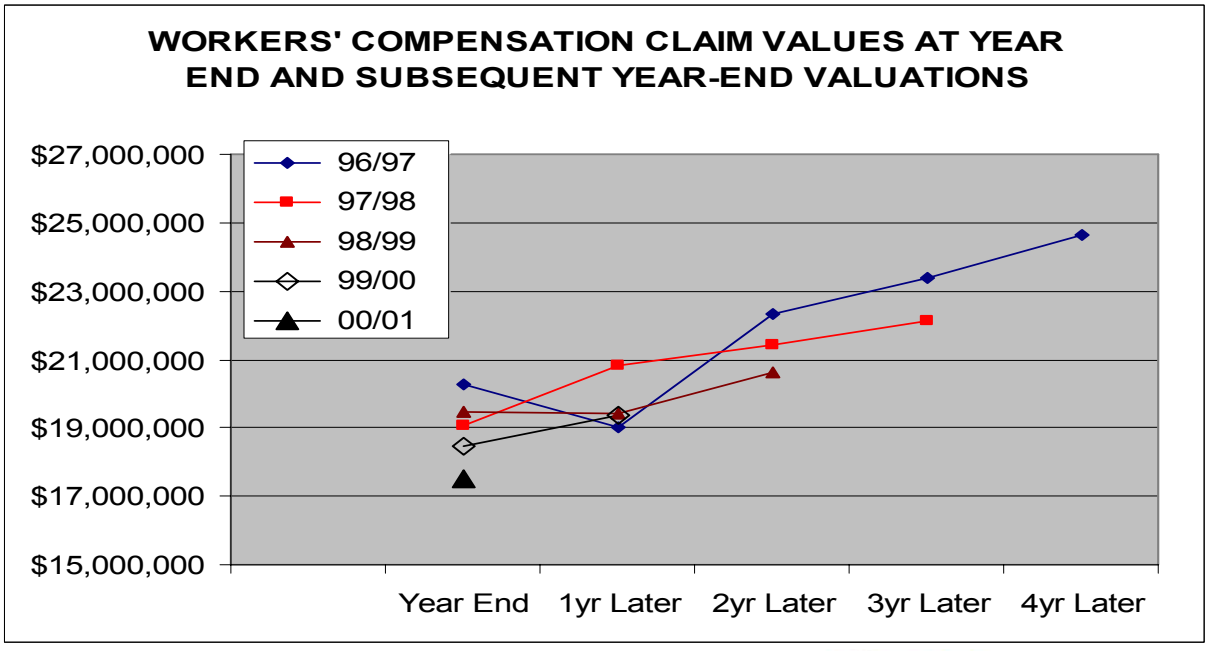
The *Corporate Systems "Scoreboard"* report appears designed to compare performance of organizational units in a common time period (unable to confirm because none of the staff was able to explain how the loss data is compiled in the report and they have been unable to reproduce the examples initially provided in the assessment process). A group of these reports were used to compare the performance of the entire organization across multiple time periods, but there was no evidence that any accounting was made for claim development from one time period to the next.

The development of claims can be seen in the following.



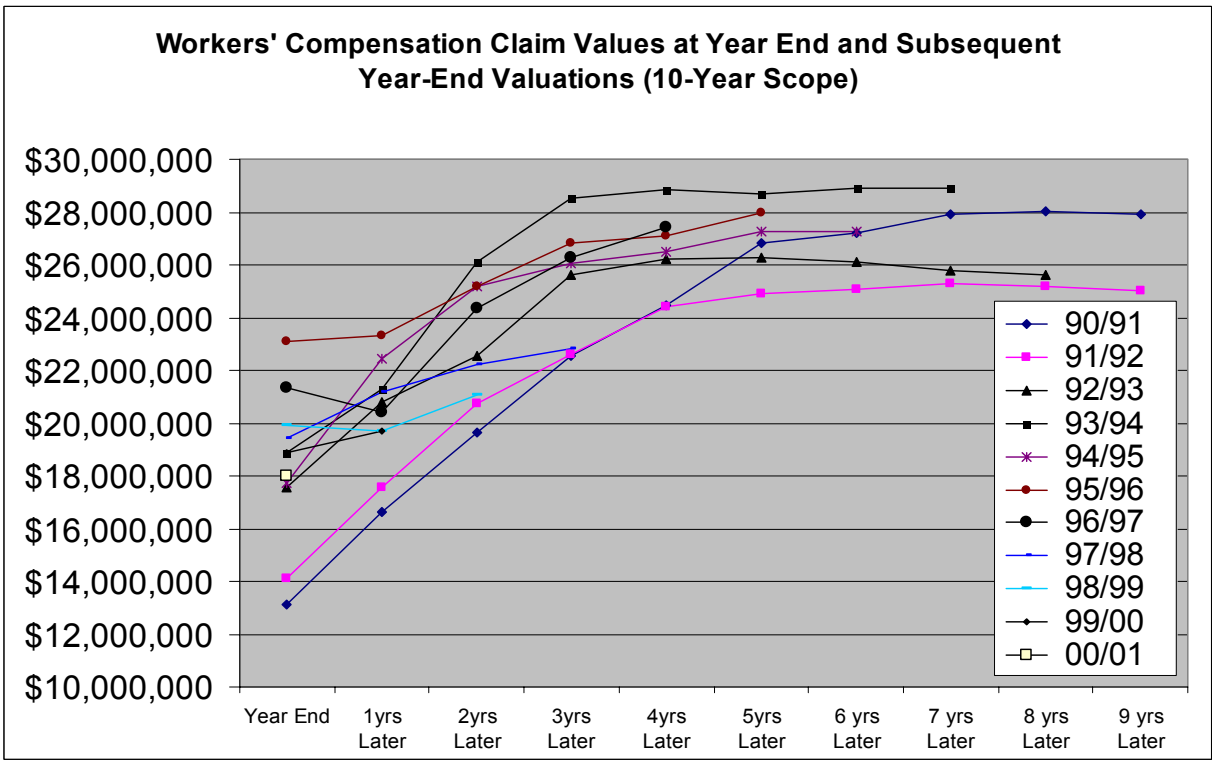
As of 6/30/97, there were 4,948 reported workers' compensation claims for the 1996-97 fiscal year. Additional claims were reported for 96-97 occurrences after the fiscal year ended. This is a common pattern for workers' compensation and other casualty lines of insurance. At 6/30/98, the total had increased to 5,832. The number of worker's compensation claims reported for occurrences in the 96-97 year continued to increase, and the number stood at 5,865 on 6/30/01. The pattern for other fiscal years is similar.

Typical development can also be seen in the following graph.



These show the estimates of total ultimate claim costs at different points in time. As claims mature, case knowledge increases and estimates of the ultimate payouts are updated. These updates generally result in increases of the estimated ultimate losses, also a common pattern for casualty lines. The fiscal year end estimate for 96-97 workers' compensation ultimate costs was $20,288,323. By 6/30/01, the estimate had increased to $24,639,370. A noted oddity was the 6/30/98 valuation of the 1996-97 losses which as $19,031,055. No further explanation was pursued as it was felt a considerable amount of time reviewing the 1996-1997 claim files would be needed. The patterns were fairly consistent otherwise.

The following graph indicates that historically, the development of workers compensation claims in the Office of Risk Management operation has begun to stabilize five to six years after fiscal year end.

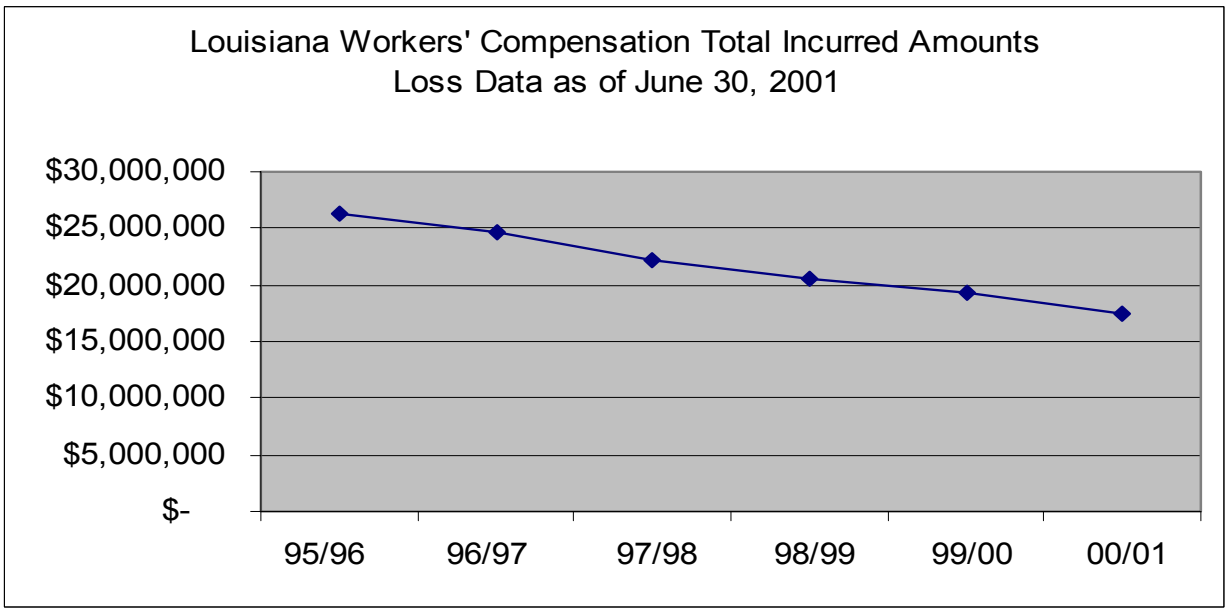


The study of these patterns, claim payout patterns and a number of external factors form the basis of the actuarial projections prepared for the Office of Risk Management by actuarial consultants – most recently, Tillinghast - Towers Perrin.

It should be noted that Tillinghast - Towers Perrin has qualified its actuarial opinions as reliant upon the information provided by Office of Risk Management and that no audit or independent verification has been made on historical data and other quantitative and qualitative information supplied by the Office of Risk Management. This is important for loss prevention because changes in the way claims are managed, particularly in the estimating of ultimate payouts, could significantly impact the measurement of success or failure in loss prevention interventions.

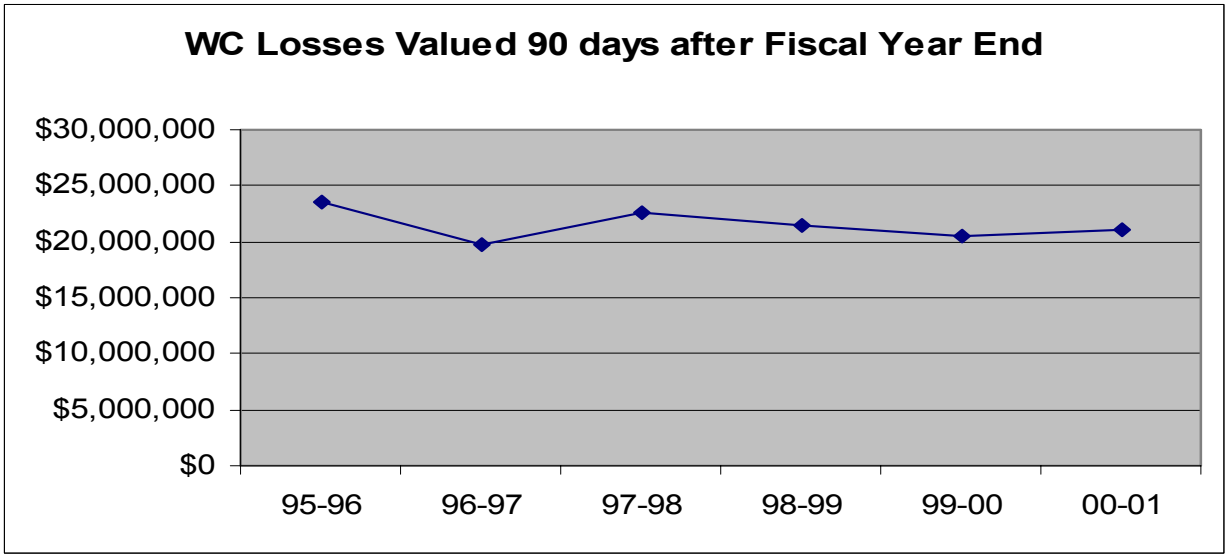
The **METHODS** Project Team is compelled to make qualifications similar to those found in the actuarial reports. It is recommended that an independent study of historical claim data be undertaken to determine

what, if any, changes have taken place in the way claims reserves are estimated and what, if any impact such changes may have had on ultimate loss projections. The problem of measuring performance with developing losses is illustrated below.

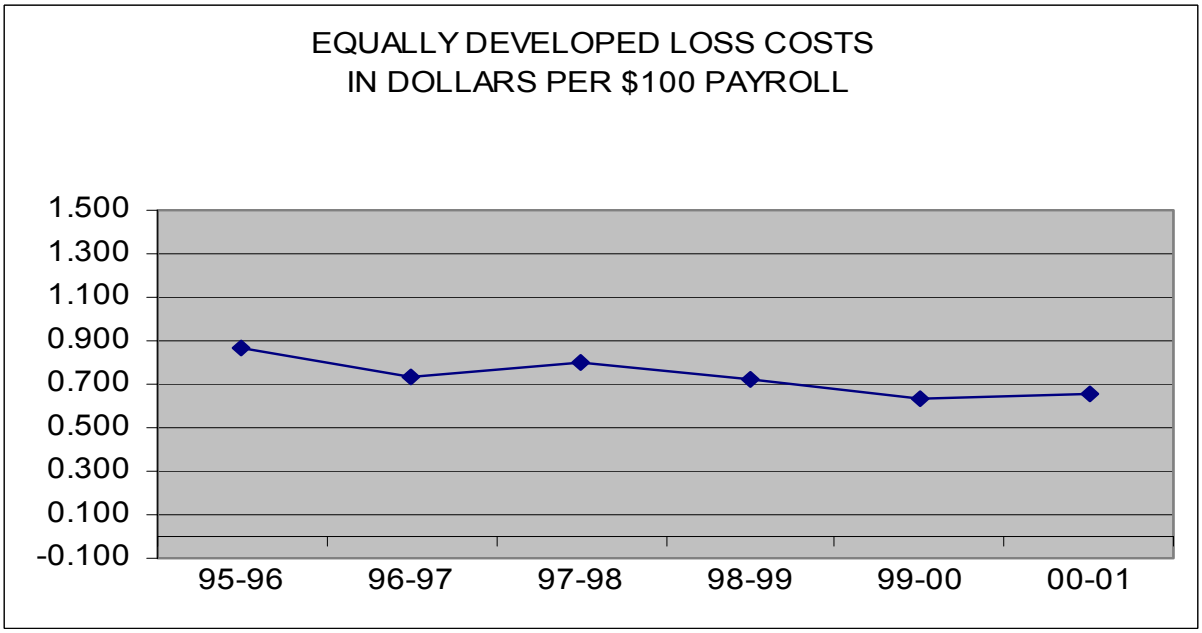


Because the development periods are shorter for the most recent years, it appears a favorable trend is underway. It is not uncommon to find this error in the analysis of loss trends in casualty insurance.

To address this, the Office of Risk Management should use equally developed losses as in the analysis loss trends. First, the Office of Risk Management should obtain Workers' Compensation losses valued ninety days after the end of the fiscal year. In this analysis, the fiscal year losses were measured at 9/30/XX, ninety days after the respective fiscal year end.



Equally developed loss costs can be calculated to unitize cost on the basis of exposure; payroll in the case of workers' compensation. A graphical presentation of the state's workers' compensation experience appears in the following chart.



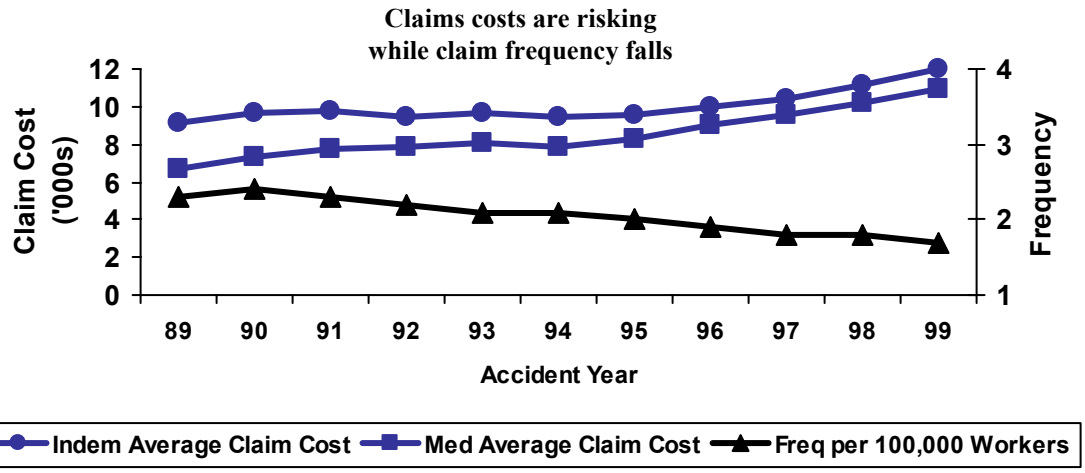
The calculations are as follows:

Equally Developed Loss Costs in Dollars per $100 Payroll

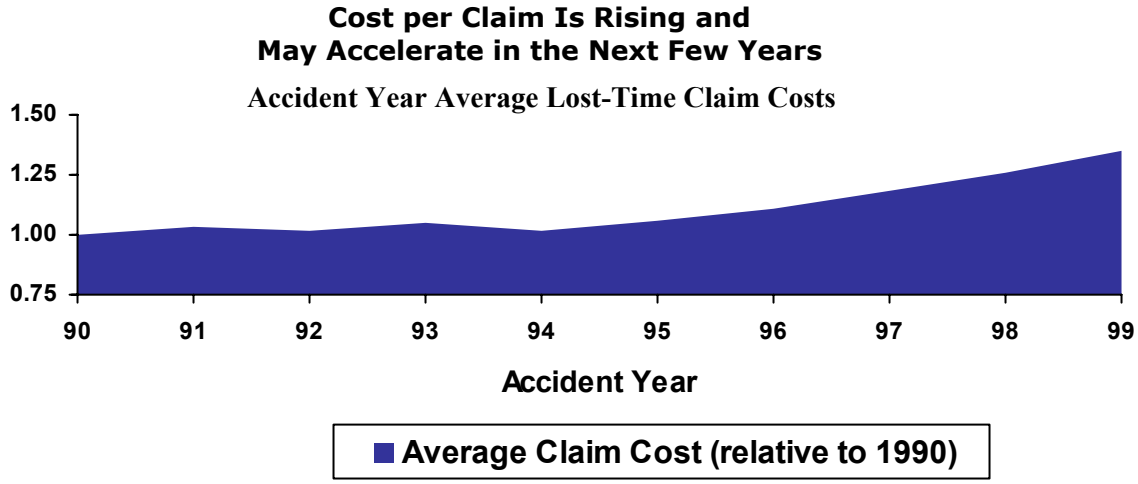
Loss Cost = Losses x 100 / Payroll

		95-96	96-97	97-98	98-99	99-00	00-01
Statewide Losses @9/30		$22.6 M	$19.8 M	$22.6 M	$21.5 M	$20.5 M	$21.1 M
Statewide Patewide Payroll		$2.73 B	$2.71 B	$2.83 B	$2.96 B	$3.26 B	$3.21 B
	Loss Cost	0.864	0.731	0.799	0.726	0.631	0.657

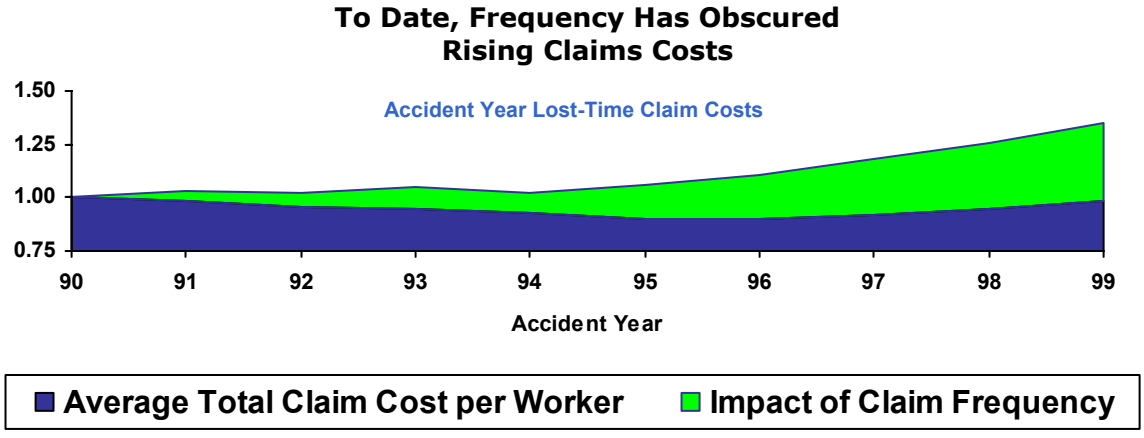
As noted earlier, development of losses for the 1996-97 year was negative in the first subsequent year. But second and later years showed growth. With this oddity aside, the trend in cost per unit exposure has been favorable in recent years with a possible inflection point in 1999-2000. Industry statistics provided by the National Council on Compensation Insurance, Inc. show a similar pattern of unit cost decrease until 1996 and an increase beginning in 1997.



Based on data through 12/31/99. Average indemnity and medical cost per lost-time claim.

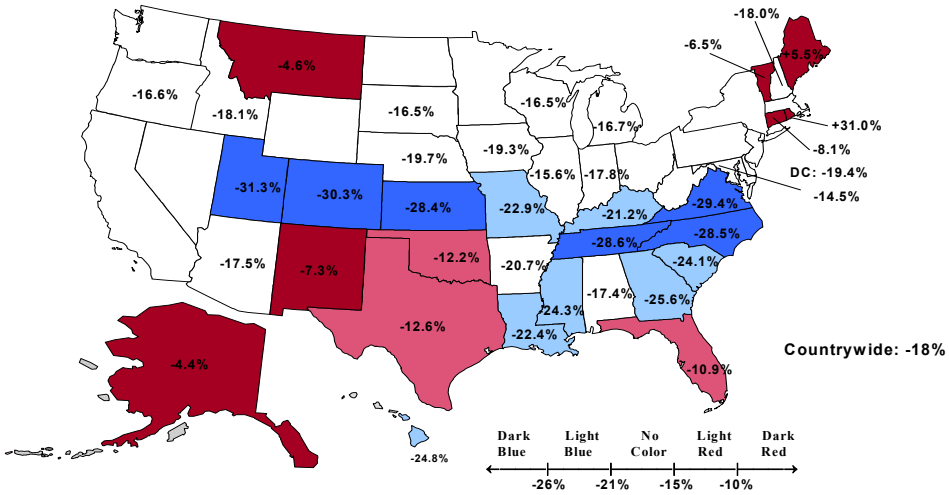


Based on indemnity and medical data through 12/31/99, developed to ultimate.



Based on indemnity and medical data through 12/31/99, developed to ultimate.

Four Year Change in Frequency of Workers Compensation Claims
(1993 to 1997 for most states)



A later inflection in the Office of Risk Management data could be due to trends considered in the NCCI actuarial analysis and not reflected in the raw Office of Risk Management case reserves.

Accrual Rates have been used to show loss reduction since the inception of the Safety Audit and Safety Credit programs, but it is felt that this indicator is not valid. The Accrual Rate is expressed in dollars per $100 payroll and, by design, represents premium rates for the workers' compensation line. It is calculated for each agency within *Corporate Systems* and published in the annual CORA reports. The formula is:

Accrual Rate = 100 x Workers' Compensation Premium / Payroll

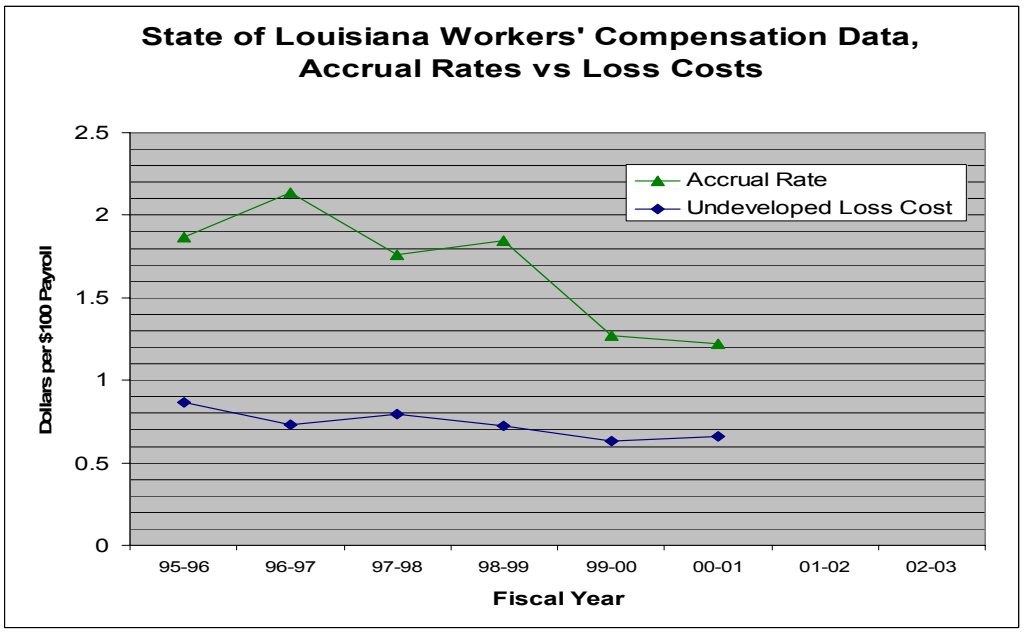
It was pointed out to us that there had been a decrease in the number of agencies having an accrual rate greater than 5.00. This analysis has become corrupted because the CORA system is being used to allocate budgeted cash need, not premium. The numerator is not real premium but rather a reflection of budgeted figures used by Office of Risk Management to request funding. The amount of cash requested has been influenced by cash reserve budgeting, commercial premium estimates, and anticipated rejection of Office of Risk Management funding requests by the Office of Planning and Budget.

1. The amount of cash reserve figured into the annual request has varied from zero to $100,000 in recent years.

2. The estimates of commercial premium for Aviation & Marine liability coverage were left out entirely for two consecutive years.

3. Staff members stated that "We just started asking for less because we know they are going to cut whatever we send to them."

A comparison of the statewide accrual rates to the statewide workers' compensation undeveloped loss costs is shown in the following graph.



Additionally, the number of agencies having an accrual rate greater than 5.00 has dropped, in part, because a number of individual rating units have been consolidated since the Safety Audit program started. The State Risk Audit and Statistics Manager pointed out this was done in the Office State Parks. Not only did the number decrease with the consolidation but also the relatively high rates for the field operations were diluted when combined with predominately low-risk office staff.

For coverage lines other than workers' compensation, loss costs should also be used to measure overall performance. The exposure units should reflect the exposure bases already being used in the cost of risk allocation calculations.

Coverage Line	Exposure Base
Workers Compensation Statutory	Regular Payroll
Workers Compensation Maritime	Maritime Payroll
Comprehensive General Tort Liability	Total Compensation
Automobile Liability	Total Mileage
Auto Physical Damage	Licensed Vehicles
Boiler & Machinery	Boiler & Machinery
Building & Property	Property Values
Bonds	Bond Units
Crime Self-Insured	Crime Units
Personal Injury Liability	Total Compensation
Medical Malpractice	Medical Malpractice Contacts
Road Bridge, Dam & Tunnel	Road & Bridge
Miscellaneous Tort (NOC)	Regular Payroll

SAFETY AUDITS AND THE USE OF AUTOMATION TO MAXIMIZE CUSTOMER SUPPORT

Despite a standardized questionnaire used to structure the safety audits, there is considerable subjectivity in the safety audit process. This is driven, to a great degree, by a massive paperwork effort on the part of the agencies attempting to pass the audit. Paper is used to document many activities and those documents must be reviewed during the audit. Included are the following:

- Safety Policy and Program Documents
- Responsibility Assignments
- Safety Training (All required)
- Accident Investigation
- Safety Inspections
- General Safety Meetings
- Employee suggestions
- Safety Committee Activities
- Employee Hazard Reporting (HAZLOG)
- Corrective Action Identification, Assignment and Closure
- Job Safety Analysis
- Fire Drills or Other Emergency Action Practice

Depending on the size and nature of the agency, the task may be huge. First, the Loss Prevention Officer must decide how much of the documentation must be read to get a "feel" for its completeness and quality, then, if any of the documentation is missing or incomplete, the Loss Prevention Officer must decide if the deficiency is important enough to warrant a "Fail" recommendation. In some cases, a single deficiency may not be judged important enough, by itself, to warrant failure, and the Loss Prevention Officer might include notice of it in the report. In another case, the same deficiency may be listed as one of many that support a "Fail" recommendation.

The Loss Prevention Officer must also decide which deficiencies warrant a formal recommendation for correction and which will be informally addressed internally with input from the local contacts. There appears to be genuine sense of service in the Loss Prevention Unit and that the Loss Prevention Officer's attempts to be reasonable in reporting their findings; however this human element coupled with the variety in the experience of the staff detract limit the objectivity of the audit results.

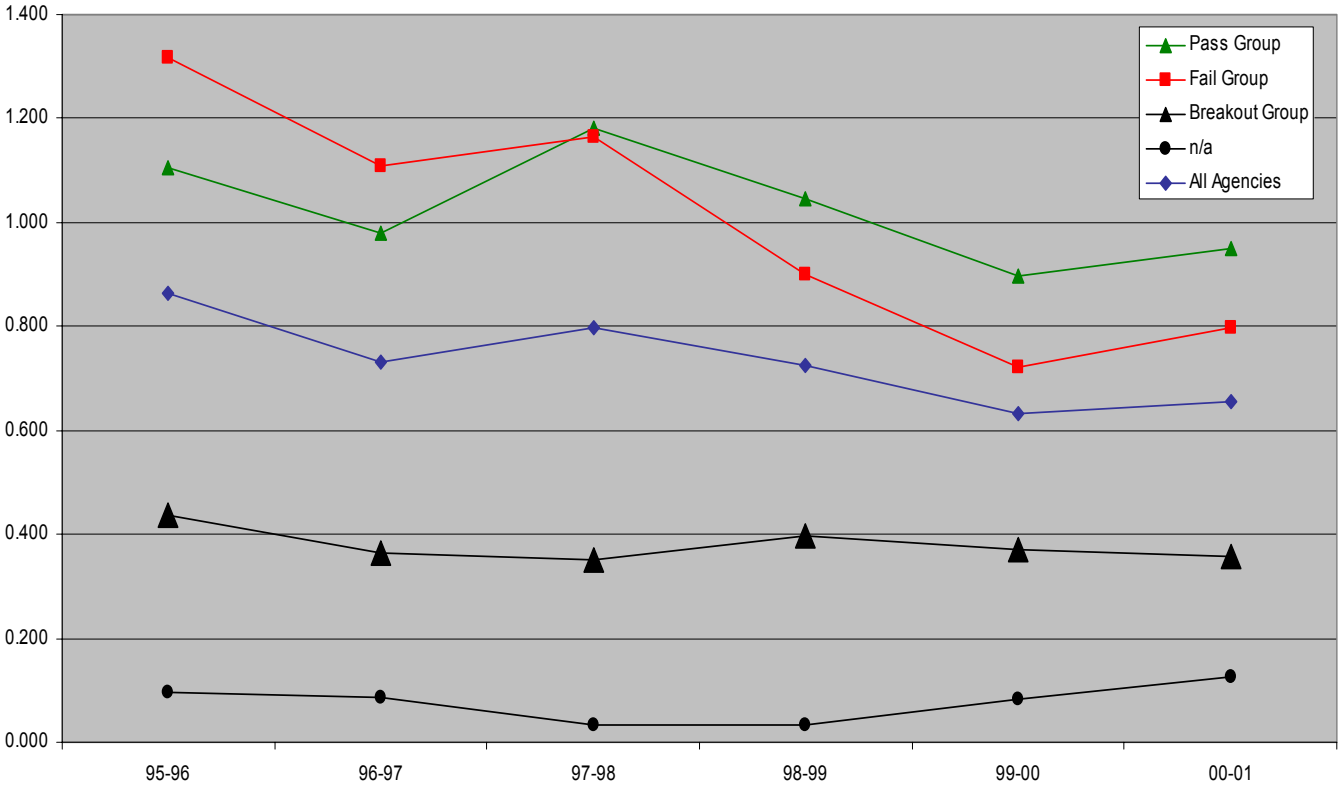
Once the location audits are completed, the Loss Prevention Supervisor and Manager collect the location audit results, the Loss Prevention Officer's opinions and

recommendations, and judge the entire agency as having passed or failed the audit. Ultimately, the Manager must decide if the noted deficiencies in the location reports are important enough to fail the entire organization.

During document review, in the interviews with staff and with agency personnel, no evidence of any measured relationship between the safety audits and a reduction in losses was noted.

Seeking to determine if such a relationship existed, loss cost trends of the agencies that had passed the audits and those that did not was closely analyzed. The results are presented as the Loss Cost by Pass / Fail Groups shown below. Surprisingly, the agencies that failed the 1999 - 2000 Safety Audit showed more improvement over a six-year period as a group than those that had passed the audit.

Equally Developed Loss Cost by 99-00 Safety Audit Pass/Fail

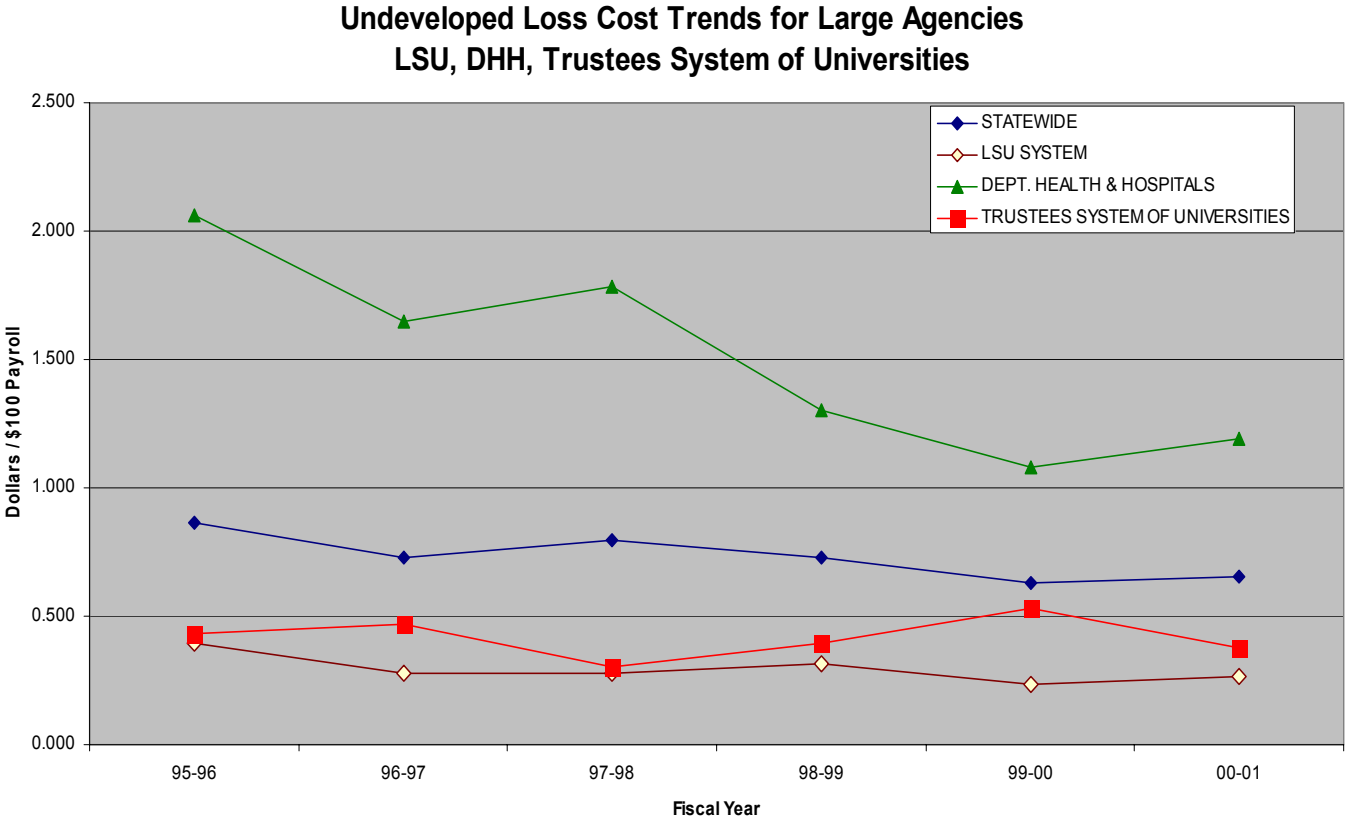


"**Breakout**" - individual operating units within the agency were individually audited and rated as having passed or failed the safety audit. The umbrella agency was not treated as a single unit in the Safety Credit Program.

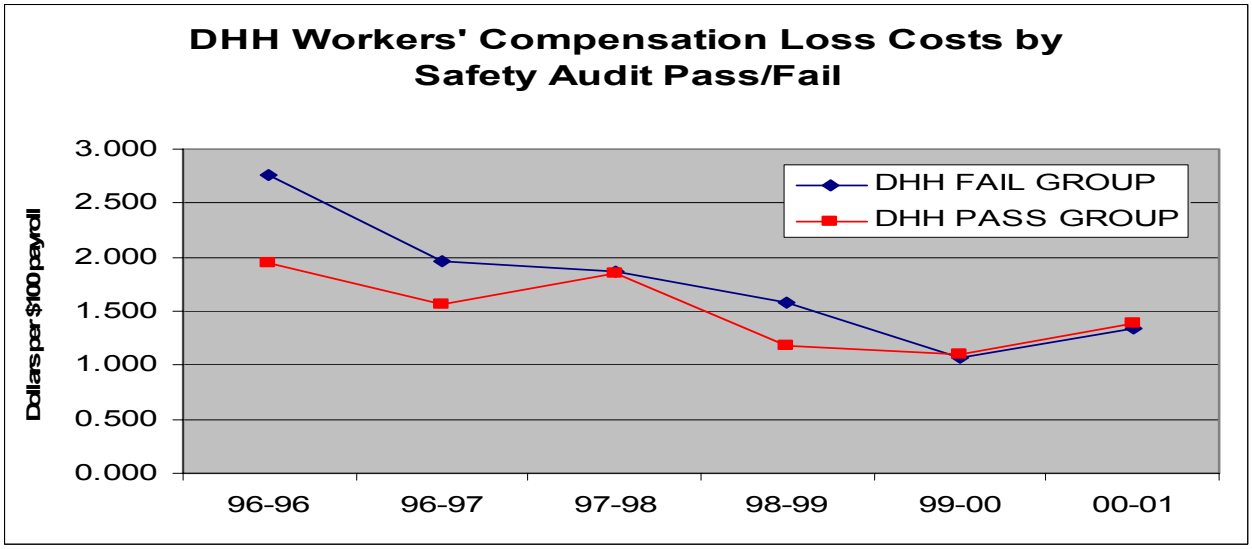
"**n/a**" - the Judiciary was not subjected to the Safety Audit in 99-00

The following chart illustrates the results of an analysis of largest agencies and found that the Department of Health and Hospitals (DHH), being one of the consistent audit failures, showed considerable improvement

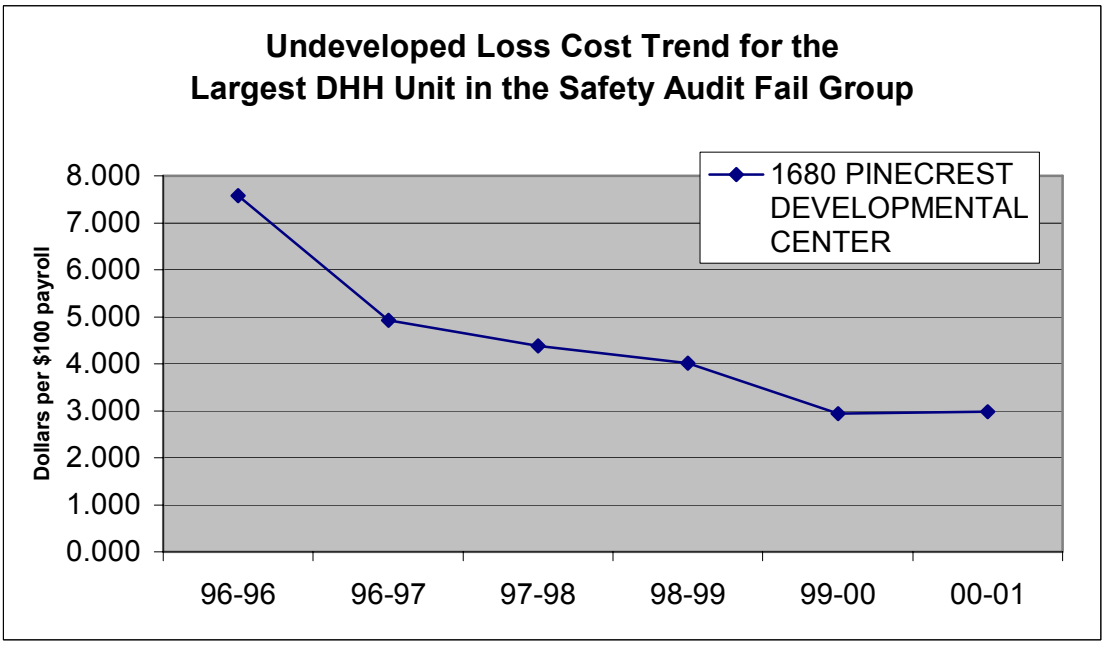
over a six-year period.



A listing of those units within the DHH that "Passed" and "Failed" the location audits was requested and compared to the performance of those groups. The next chart shows both groups improving with the fail group probably improving more.



An analysis of the Pinecrest Developmental Center shows improvement in the largest unit in the DHH fail group. Follow-up interviews were scheduled and held with DHH staff to determine what the agency may have been doing in recent years to improve losses.



In the majority of the interviews conducted inside and outside the Office of Risk Management, a perception exists that the implementation of the Premium Safety Credit Program and the Safety Audits has made state operations safer. While the data does show improvement, the improvement cannot be entirely attributed to the Safety Audits, because the improving trend is consistent with workers' compensation industry and federal labor trends. Also, the analysis relies heavily on the assumption that individual case loss reserving practices have been consistent since 1995. While the Safety Audits and the Safety Credit Program are motivators for improving safety and reducing losses, the Audit Result (Pass or Fail) is not, by itself, a useful predictor of loss performance.

To support more objective safety management practice evaluations and reduce the paperwork burden on both client-agency personnel and the Loss Prevention Officers, the Office of Risk Management should develop and make available to all agencies, an electronic safety management data system that will allow each agency to record safety management information in a common data repository and from which, management information can be drawn and objective measures of safety management practices can be made. It is believed that such a system can be purchased, installed, and started for a one-time cost of approximately $900,000.

It is recommended that the Loss Prevention Standards prescribed by the Office of Risk Management under LA R.S. 39:1536 be changed to match the set of standards outlined below. The specifications for the automated safety management system should support these standards.

Recommended Loss Prevention Standards

	Level 1	Level 2	Level 3	Level 4	Level 5
Management Commitment					
Program Assessment in the past 12 months	12	18	24	30	30+
Assessment by a Credentialed Professional*	Yes	Yes	No	No	No
Needed Programs are written & Active	Yes	No	No	No	No
Responsibility for each program is assigned	Yes	No	No	No	No
Worksite Analysis					
Physical Assessment in past 12 months	12	18	24	30	30+
Assessment by a Credentialed Professional*	Yes	Yes	No	No	No
Percent on-time recommendation compliance	95%	90%	85%	75%	0%
Training Assessment in past 12 months	12	18	24	30	30+
Assessment by a Credentialed Professional*	Yes	Yes	No	No	No
Hazard Prevention & Control					
Percent on-time inspections	95%	90%	85%	75%	0%
Percent on-time corrective actions	95%	90%	85%	75%	0%
Accident Investigation Records complete	95%	90%	85%	75%	0%
Percent on-time corrective actions	95%	90%	85%	75%	0%
Safety & Health Training					
Percent on-time training	95%	90%	85%	75%	0%
Proficiency					
Percent safety meeting attendance	95%	90%	85%	75%	0%
Employee Involvement					
Safety Committee Attendance	95%	90%	85%	75%	0%
Meetings per Committee in past 6 months	6	6	5	5	4-
Employee Participation in at least 2 processes	50%	40%	30%	20%	0%
Employees reporting hazards					
Employees reporting near-misses					
Employees completing JSA's					
Employees completing observations					
Employees making suggestions					

* Any active practitioner who meets the standards outlined in LA R.S. 23:1291 - Title 40, Part I, Chapter 9, Rule 903

Comparison of Safety Management Practice Standards listed by current safety audit item

	State Loss Prevention Safety Audit Primary Audit Items	Current Standard	Recommended Standard
1	Operational Safety Plan*	Yes / No **	Program assessed by a credentialed professional recorded in the system in the past 12 months Physical assessment by a credentialed professional recorded in the system in the past 12 months % of resulting recommendations completed on time
2	Assignment of Responsibility	Yes / No	Responsible party name recorded in system for each plan or program
3	Inspection Program	Yes / No	% inspections completed on time % corrective actions completed on time
4	Job Safety Analysis (JSA)	Yes / No	No Std.
5	Accident Investigation	Yes / No	% accident investigation records completed % corrective actions completed on time
6	Safety Meetings	Yes / No	% attendance
7	Safety Rules	Yes / No	Included in Item No. 1
8	Training	Yes / No	Training assessment by a credentialed professional in the past 12 months, % of training assignments completed on time, on-line training proficiency ratio, attempts/answers, 1.25 or less
9	Safety Record Maintenance & Self-Audit	Yes / No	All records maintained in system.
10	First Aid	Yes / No	Included in Item No. 1
11	Emergency Plan	Yes / No	Included in Item No. 1
12	Hazardous Materials Program	Yes / No	Included in Item No. 1
13	ADA Program	Yes / No	Included in Item No. 1
14	Violence Prevention Program	Yes / No	Included in Item No. 1
15	Substance Abuse Program	Yes / No	Included in Item No. 1
16	Return-to-Work Program	Yes / No	Included in Item No. 1
Other	Employee Participation		
	Hazlog	Yes / No	% employee participation
	Suggestions	Yes / No	% employee participation
	JSA's	No Std.	% employee participation
	Observations	No Std.	% employee participation
	Near-Miss	No Std.	% employee participation

* A consistent complaint among the agencies is that the ORM expectations have not been clearly communicated, and the interpretations of compliance in the policy and program documents have been inconsistent. With the revised standards, each agency will have to allow a credentialed professional (ORM LP Officer) to review its policies. The LP Officer will be required to make specific recommendations for improvements or changes needed. The agency will be measured by timely compliance with recommendations.

** In the current system, the Loss Prevention Officer must register a "Yes" or a "No" for each item on the safety audit list. There are no policies and procedures describing what constitutes a "Yes" score and there is no apparent standard for the number of "Yes" answers needed to "pass" the audit.

SAFETY PRACTITIONER STANDARDS

The Office of Risk Management Loss Prevention Unit should establish a plan to have all Loss Prevention Officers meeting the Safety Professional / Engineer definition provided in Title 40, Part I, Chapter 9, Section 903 (R.S. 23:1291) by 12/31/05. The plan should be completed no later than 6/30/02. These standards were established by the Department of Labor as part of the Cost Containment Program for private employers within the state. An analysis of the current staffing education and experience is outlined below. Based on the information provided, seven of the twelve professional staff currently meet at least one of the standards.

ORM LOSS PREVENTION STAFF QUALIFICATIONS COMPARED TO RECOMMENDED STANDARDS*

Standards	Total Qualified Staff
B.S. Engineering or Science + 5 Years, or Masters + 4, or Ph.D. + 3	3
Assoc. in Engineering or Science + 8	0
10 Years professional safety experience	4
Certified Safety Professional	0
Certified Hazard Control Manager	0
Certified Industrial Hygienist	0
Safety Professional / Engineer	0
None of the Above	5
Total	12

*Title 40, Part I, Chapter 9, Section 903" (R.S. 23:1291)

SAFETY INCENTIVES

"Safety" incentives have been used and should be considered by all agencies. Cash awards are being offered to the Department of Health and Hospitals (DHH) Safety Coordinators to motivate efforts directed at passing the Safety Audit. Similar incentives have been considered at the Department of Natural Resources (DNR). In these arrangements, only a limited number of employees had reward opportunities.

At the Department of Transportation and Development (DOTD), safety jackets have been given out in some units. To qualify for the awards, it was necessary for participating employees to complete a period of work without being involved in a "preventable" accident. Also, the entire unit to which an employee was assigned, would have to work the entire period without a "preventable" accident in order for each of the employees to be awarded. The local Safety Committee was identified as the deciding body on deeming accidents "preventable" or "non-preventable". This kind of arrangement creates a barrier to improving safety in two ways:

1. The arrangement creates a disincentive to report accidents. If the accidents are not reported, corrective actions cannot be identified or taken.

2. The individuals serving on the safety committee may be less inclined to deem an accident "preventable" if their own individual safety awards are at stake. When an accident is

deemed "non-preventable," it is not likely that measures to prevent the accident from happening again will be identified.

The audit report for DOTD District 7 included a recommendation to have the safety officer and supervisors effectively trained in conducting accident investigations. The Loss Prevention Officer, in preparation for the audit, had reviewed several accident records and stated that many of those deemed "preventable" could have been prevented, in his opinion.

Within the Department of Corrections (DOC), cash awards have been offered to employees who attend the safety training seminars offered by the Office of Risk Management. The idea is a good one, but because there is no testing in these training events, students are not required to demonstrate a knowledge gain, in order to get credit for the course. They need only attend.

The individuals with the most influence in reducing accidents are those doing the work. To be successful, it is critical that management facilitates the contributions of the entire workforce and encourages as much participation as possible in the identification and mitigation of hazards.

Incentives, when connected to proactive loss prevention activity, can be a valuable tool for increasing employee involvement.

In addition to training, the most common ways to get employees involved are Hazard Reporting, Near-Miss Reporting, Job Safety Analysis (JSA), Behavior Observations and Suggestions.

Hazard Reporting (referred to as **HazLog**) provides an opportunity for employees to report conditions that could lead to accidents. If the remedy is within the employee's ability and authority, he is encouraged to act and report the event.

Near-Miss Reporting is a system for identifying accidents that did not result in injury or damage, but could have. Employees are encouraged to report what happened, what could have happened, and what they would recommend to prevent a similar event in the future.

In a **JSA**, an employee is asked to identify a dangerous job within the scope of his work. The job is broken down into steps, the hazards of each step are identified, and the means of eliminating or avoiding each hazard is described. The result becomes a learning tool for others and the process develops advocacy among the participating employees.

Behavior Observations are used to measure the frequency of safe and unsafe behaviors in the work environment. Employee groups are involved in the identification of critical operations and the definition of safe and unsafe behaviors for each. Employees are observed by their coworkers, with the employees' permission, to establish a benchmark. Goals for increasing safe behaviors and decreasing unsafe behaviors are established and continuing observations are reported, allowing the entire workforce to track progress.

Suggestion Boxes are simple systems for soliciting ideas from employees. These may be suggestions for improving safety, but any insights for improving operations can be solicited in this way.

Since the Department of State Civil Service has already implemented a policy to support safety incentives, they should be more widely offered to motivate employee participation in loss prevention activities such as these. All state employees should have an equal opportunity to

participate for an initial period of three years. A statewide goal of 15% reduction in Workers' Compensation Loss Costs should be established and communicated to all state workers. The workforce should be offered a three-year extension of the incentive program if the goal is reached and sustained. A budget should be established to support the safety incentive program. A budget of $1,620,000 is recommended for the first year based on 60,000 employees and incentive award values equaling $2.25 per employee per month. The specifications for the safety management system should support employee participation and the incentive program.

TRAINING

It appears a considerable amount of training has been provided or facilitated by Office of Risk Management Loss Prevention staff. Twenty-eight safety-related courses are being taught at no charge to the state agencies and thousands of state employees are attending. But, the delivery of training has been limited to disbursement of information with no testing. Training activities should include an assessment of students so that a knowledge baseline and/or a knowledge gain can be measured.

The assessments should include performance measures where students are required to describe and/or demonstrate skills in order to get credit for completing a course. Learning Objectives should be clearly stated at the beginning of each course. The American National Standard ANSI/ASSE Z490.1-2001 Criteria for Accepted Practices in Safety, Health, and Environmental Training should be used as a guide for the development and delivery of Office of Risk Management Loss Prevention training.

The current training delivery system involves a great deal of travel, classroom time, and paper. Without more automation, student testing, feedback, and record keeping would require considerably more resources than the Office of Risk Management currently has available to train agency-client personnel. Safety training can be improved at a reduced cost with the use of an automated Learning Management System and with the delivery of training over the Internet where the Internet formats are appropriate for the subject matter. The State Loss Prevention Manager has explored these areas in September and October 2001 and requested funding to explore the use of some of these formats. One initiative undertaken by the DHH to use online learning in lieu of classroom learning for safe-driver training is also noteworthy.

One initiative undertaken by the DHH to use online learning in lieu of classroom learning for safe-driver training was identified. A return on investment for the initiative was estimated to be 47% without consideration for time saved in the keeping of records. It is believed the estimate for travel time saved is conservative based on interviews with the Loss Prevention staff, DHH staff and with students in attendance at other safety training events. The calculations are listed below.

DHH Driver Training Initiative
ROI Calculation

	Online Training	Classroom Training	References
Course Time (hours)	0.433	1.5	Average reported by DHH. ORM based on scheduling documents.
Travel Time	0	0.5	Conservative assumption based on interviews
Total Time	0.433	2.0	
Student hourly wage	$ 14.10	$ 14.10	Per DHH estimate
Student Time Cost	$ 6.11	$ 28.20	
Course Cost	$15	0	Per DHH
Per Student Cost	$ 21.11	$ 28.20	
Test Time	Included	No Test	Course reviews
DHH Students	653	653	Number of Online Students
Investment	$9,795		
DHH population costs	$ 13,781.76	$ 18,414.60	Actual costs based on actual learning events.
ORM Students	4630	4630	Number of Driver Training Students reported by ORM for the period 7/1 to 12/1/01
ORM poplation costs	$ 97,717.54	$ 130,566.00	Projected 5 months all agencies
Return on Investment		47%	

The safety management system should include specifications for learning management and for the Internet-delivery of safety training where appropriate for the subject matter.

POLICIES, PROCEDURES AND PRODUCTIVITY

No policy and procedure manual is currently in use. A manual was produced and described as being under revision. This revision should be completed as soon as possible. Policies and procedures should be written for all Loss Prevention activities including Safety Audits, Investigations, Building Appraisals, and Training. The procedures should be updated to reflect changes as they occur and should be reviewed annually. The procedures should be used as a benchmark for self-audit.

For quality control purposes, management should perform periodic, random, follow-up audits to monitor the performance of Loss Prevention Officers. This activity should be included in the policies and procedures document.

The Loss Prevention Unit counts tasks performed in a number of areas on a monthly basis. The counting includes efforts in the four major categories of activity, Audit, Appraisal, Training and Investigation. A report has been prepared for the State Risk Director at the end of each month but it is not known how this information is used at the Director level. This report should be a resource measure included (available man-hours or person-days) in this exercise so that productivity can be measured per unit resource, not simply in bulk.

CAUSE-OF-LOSS CODING

The Targeted Loss Prevention projects should rely heavily upon accurate cause-of-loss coding to be successful. Several claim management staff were interviewed and no formal quality control process for the use of these codes was provided. Generally, the clerks and/or adjusters have been allowed to select, from a list, and assign the codes having corresponding descriptions most closely matching the accident information. From time-to-time, codes have been added to the list when the adjusters and supervisors decided that there was not a description on the existing list to match a cause-of-loss that seemed to have been frequently reported. It was also indicated that the "civil commotion" cause-of-loss code had been used as a "catch all" in some cases where there did not appear to be any adequate descriptions.

A report of all the civil commotion claims since the beginning of the current fiscal year was requested. The results are included as an Exhibit.. Most of the accidents did not seem to be related to occurrences of civil commotion. Several indicated losses related to missing property or property damaged by other means. There were a number of cases of glass broken by rocks thrown from lawn equipment. At the Louis Jetson Correctional Center, forty-one civil commotion claims totaling more than $14,000 were described as having to do with mowers. A re-evaluation of all cause-of-loss codes and the development of quality control efforts should be undertaken to achieve a high degree of data quality in this area.

INVESTIGATIONS

The Loss Prevention staff regularly responds to requests for investigation of accidents. The requests appear to come mostly from the Office of Risk Management claim staff. Evidence of confusion about this process was found. The confusion is directly related to the lack of a procedure manual for the loss prevention operations.

The Loss Prevention staff believed some claim staff did not understand which claims Loss Prevention should investigate and which they should not. Some of the requests did seem a bit out of order, but this lack

understanding can be attributed to the lack of guidelines. It was indicated that the results of the investigations and corresponding recommendations are routinely communicated to the agencies within which the claims originated, but no evidence of a clear pattern was identified during the assessment. Procedures for selecting, requesting, conducting, reporting, and distributing the accident investigations should be established and communicated within all parties participating in the process.

BUILDING APPRAISAL

The Loss Prevention Unit is charged with maintaining replacement cost estimates for fixed assets owned by the state and covered by the self-insurance program. Existing structures are re-evaluated on a 5-year schedule. Procedures exist whereby others notify the Office of Risk Management Loss Prevention when new assets are purchased, or built. It was reported, however, that staff regularly identifies new assets during re-evaluation. This suggests that the notification process is not completely effective. Such inaccuracies could result in cost-of-risk allocations that are less than equitable. This appeared to be a minor issue, but worthy of noting and should be monitored.

The Marshall & Swift system is used for developing appraised values. This software tool is commercially available and was analyzed in detail.

Claims Unit

Ann Wax was appointed State Risk Claims Officer in January 2002. The Claims Unit is divided into six groups or departments:

- Commercial General Liability
- Medical Malpractice
- Property
- Road Hazard
- Transportation
- Workers' Compensation

SUMMARY OF FINDINGS AND RECOMMENDATIONS

A common managerial belief is that a lack of planning leads to complacency and then to failure. There is a total lack of planning within Claims Operations. The concomitant complacency and ultimate failure of Office of Risk Management to achieve its mission is the observed result. Personnel within the Claims Unit work hard. There is an almost frenzied atmosphere with managers and claim professionals alike working diligently to attend to the day's challenges. The failure at all levels of management to deliver basic organizational needs in planning, organizing, staffing (including training), directing and controlling has resulted in an unacceptable claims product too often characterized by waste, inefficiency, and missed opportunities. Extensive interviews with all levels of personnel alerted this team to the existence of serious problems within Claims. A sampling of over 120 claim files determined that claim file quality is at unacceptable levels in workers' compensation, commercial general liability, transportation, and road hazards. Notable exceptions were found within the property and medical malpractice product lines. These findings suggest sizeable opportunities for operating efficiencies exist. These opportunities, if realized, will translate into significant cost savings to the Office of Risk Management and the state as a whole.

The rapid attainment of available savings represents an unprecedented challenge to the present management team. With a clear vision and a strongly articulated reason for change, the management team, working with all levels of personnel, can find solutions to its considerable problems. This report is confined to actual findings and quantification of unrealized savings.

CLAIM FILE REVIEW AND ANALYSIS

An overview by department or line of coverage follows. The quality of the claim files reviewed is totally unacceptable. Were the organization's operations at a level at least equal to industry average, annual claim payments could be reduced by 20% - 40% or more. The claim files were poorly handled in most categories.

Reserves were so inaccurate as to be generally useless for managerial purposes. Deserving claimants bringing small, but very real, claims against the state were often surprised by slowly moving, impersonal, drawn-out claim handling. Conversely, seriously injured claimants with negligible theories of liability often succeeded in obtaining large, even staggering, verdicts against the state. Injured state employees returned to work at their will. If they chose to remain on disability, there was seldom any active effort to assist them in returning to gainful employment. Their medical bills were paid with scant attention to reasonableness. No evidence of any diagnostic tests being challenged at pre-certification was noted even when the same test had been run within the previous year.

Claim files, claim desks and claim offices were uniformly without order. There was a distinct feeling of a lost sense of professional pride throughout the Office of Risk Management. Most disturbing was the lack of any written plans at the managerial or supervisory levels aimed at correcting deficiencies that were freely acknowledged. There is no shared feeling of responsibility among departments. The former executive management team was uniformly blamed for all the ills that afflict the organization. Yet, even the simplest corrections were seldom taken at the supervisory level. This observation is important to any eventual change within the organization. Expectations must be changed before change itself can occur. Chief among those expectations should be the challenge to bring about changes from within starting at the lowest levels and working up. Individual initiative, especially among the front-line supervisors, must be instilled and relatively quickly.

To achieve this dramatic and necessary change, these same individuals must be empowered. This can occur through a lessening of hour-to-hour and day-to-day close supervision. This supervision needs to be replaced with a set of dependable and effective performance monitors. By the end of the fiscal year, each supervisory unit and every department should be expected to have produced a written action plan laying out what improvements are to be made over the next twelve months. If the current executive management team does the same by concentrating on providing the necessary resources and supervisory training and coaching, the process will launch smoothly and grow throughout the years. As savings begin to be realized, confidence will grow. This process precludes an authoritarian reaction to this essentially negative report. It is precisely that approach that has led to the current conditions. There will need to be a rush to improvise, at least initially, some of the measurements that will be used. These measurements can be developed. Some assistance particularly during Year 1 by outside consultants would be desirable to help instill the skills necessary for the coming transformation within the Office of Risk Management. With empowerment should come close support available when needed.

Leadership should paint a very clear picture of what the new claim will look like (e.g., 24 hour contact, recorded statements from all parties, comments in the file regarding subrogation potential, referrals for fraud, appraisal requirements, etc.). And, they should allow the front-line supervisors to determine how best to implement these changes.

WORKERS' COMPENSATION OVERVIEW

State Risk Claims Manager	1
State Risk Claims Supervisors	4 (3 in Baton Rouge; 1 in the Alexandria area)
State Risk Claims Adjusters	13
Insurance Claims Examiners	4
Clerks	3
Total Staff	**25**

The State Risk Claims Manager reports to the State Risk Claims Officer.

ADJUSTER-HANDLED INDEMNITY FILES: 16 REVIEWED

CATEGORY	ACCEPTABLE	MARGINAL	UNACCEPTABLE
COVERAGE	94%	6% (1 FILE)	0
INVESTIGATION	19%	0	81%
RESERVES	6%	13%	81%
MEDICAL MANAGEMENT	13%	0	87%
DISPOSITION	0	13%	87%
RECOVERY/SIF	31%	6%	63%
LITIGATION MANAGEMENT	1 file qualified and was acceptable		
OVERALL	0	19%	81%

EXAMINER-HANDLED FILES: 20 REVIEWED

CATEGORY	ACCEPTABLE	MARGINAL	UNACCEPTABLE
COVERAGE	100%	0	0
INVESTIGATION	45%	0	55%
RESERVES	50%	0	50%
MEDICAL MANAGEMENT	55%	5%	40%
DISPOSITION	30%	0	70%
RECOVERY/SIF	81%	0	19%
OVERALL	30%	35%	35%

Thirty-six files were reviewed consisting of 16 adjuster files and 20 Examiner files. Files reviewed covered dates of loss from 1992 to 2001. Files were selected by the Office of Risk Management staff. One file was closed. All other files were in an Open/Reopen status. The number of files reviewed is not sufficient to make definitive numerical-based judgments on the overall claim file quality of the unit. The trends observed would not be expected to change significantly if more files were reviewed. Categories reviewed and percent files found acceptable by category and overall are as shown. Files generally lacked any meaningful investigation. In It was determined that workers' compensation unlike the other product lines tries to avoid expenditures for independent adjusting expense. They rely more on investigations handled directly by the assigned claim representative. There is an obvious lack of basic investigation in the claim files reviewed. This trend, like all of the trends observed, seems consistent over time rather than being a recent phenomenon. Recorded statements were seldom seen in the files. Injured workers were not interviewed. Witnesses and

employers were seldom interviewed. Medical reports were received and bills paid. Activity sheets in the files generally recorded the inputs from medical providers and the outputs in terms of invoices paid. There was a total lack of Action Plans in the claim files. Cases were not seen to be worked towards any stated objective.

File supervisors handled incidences of inadequate reserves discovered during the daily "forecast" by increasing the reserves to levels sufficient to allow payment of pending requests. This is being done without dialogue with the assigned claim representative. The result is a form of *institutionalized step reserving*. Claim representatives develop a lack of attention to adequate and meaningful case reserves realizing that the supervisor will correct inadequate reserves. Few if any instances of meaningful and documented supervisory guidance in the files reviewed were noted. In short, cases are managed on a reactive basis without supervisory oversight. Third-party recoveries as well as Second Injury Fund (SIF) opportunities were missed. This was to be expected given the lack of investigation in the files.

The lack of aggressive claim handling techniques particularly with respect to return to work initiatives contributes to prolonged claim activity and payments. Claims were observed where the attending physician had released an employee to light duty, the vocational coordinator assigned to the case had met with the employer and signaled that light duty was available, yet the employee was never notified to return to work and payments continue to be made for temporary total disability. No use of labor market surveys was evident. These are often necessary in providing employment when a return to the original employment status is not possible.

Medical case management procedures require pre-certification by the claim representative only in cases of inpatient hospitalization. Expensive diagnostic testing is being allowed to occur without appropriate intervention. Repeat requests for magnetic resonance imaging (MRI) at costs of $1,000 each are performed if the employee changes physicians. These can generally be denied without debate and previous test results furnished to the new physician. Claim representatives do not appear trained to provide this level of utilization review.

Interviews with staff members determined that there is a total lack of confidence with at least two of the three current departmental supervisors. These supervisors have limited knowledge of workers' compensation. These same supervisors indicated that they have received little actual orientation or training to enable them to properly perform their duties. Supervisors are not cognizant of all of the procedures and processes employed by their representatives. As a result, efforts to incrementally improve processes are lacking. An example would be the workflow issue of bill review. State law requires that medical providers be reimbursed within 60 days of receipt of the bill. Bills arrive at Office of Risk Management and are routed to the assigned adjuster. The adjusters use a 30-day diary and are allowed to "drop-file" daily mail for review when the file comes out on diary. At diary, which could be up to 29 days later, bills requiring medical bill review by the outside vendor are only then processed for submission to the vendor. As the vendor's explanation of benefit report is received, it can likewise be "drop-filed for up to 29 additional days. Payment is made finally by authorizing the payment on the explanation of benefits and forwarding this document to the clerical assistant for entry into the system. There are backlogs here as well. This process is not geared to complying with the mandated 60-day rule. It would seem that the state would be a role model for actual compliance with stipulated rules and procedures.

Less than 20% of all workers' compensation claims account for more than 80% of all workers' compensation expenditures. Triaging claims in efforts to provide appropriate attention to the more deserving claims is an effort that promises significant rewards for the staff at Office of Risk Management. The return-to-work

program mandated by the legislature has not been enacted. There were problems with the RFP and subsequent administrative challenges. Vocational rehabilitation expenses are often unchecked in claim files. Two of the files reviewed had charges exceeding $11,000 and $16,000 respectively. In neither case was the employee successfully returned to gainful employment.

All of these file-level trends point to concern over the lack of (1) adequate orientation and training of staff and (2) the lack of a quantitative orientation of the management team. New hires are placed on the job with little to no training. Training is generally thought of as consisting of attendance at off-site seminars and meetings. There is no concept of on-the-job training occurring on a structure, timely basis. Supervisors as well as the manager cannot answer basic numbers-oriented questions. They receive no reports detailing on a monthly or quarterly basis the total expenditures for independent adjusting, medical case management, or vocational rehabilitation efforts. Average claim payments for closed and pending files are not tracked and thus cannot be compared to averages published annually by the state's Office of Workers' Compensation.

Claim settlement and negotiating techniques seem to be poorly understood and seldom used in the department. In one file, a lingering case had a settlement demand from the employee's attorney but the demand had not been acknowledged four months later. Certainly there are cases that are being handled properly and settlements are occurring. However, this is not occurring consistently and in a structured way. Adjusters are preoccupied with essentially clerical-level tasks and supervisors also spend an inordinate amount of time "putting out fires", attending to clerical issues, sitting in on Claim Council reviews and the like rather than planning, organizing, and controlling their units' performance.

Efforts to improve reporting time from the various state agencies to the Office of Risk Management while showing some improvement still leave the Office of Risk Management at times with unacceptable delays in receipt of new claims. At times, surgeries have already been performed and the agency is reporting the claim late because of pressure for payment from providers.

A process of identifying late reporting and providing feedback to appropriate agency personnel should be implemented. At least one state agency interviewed voiced concern stating that of 96 lost time claims reported, all 96 claims were judged compensable and paid even thought they felt some of these claims were fraudulent. Anti-fraud efforts are not strong in the workers' compensation department. Fraud investigations are equated with fraud convictions that admittedly are hard to prove. However, the more common success of fraud investigations is the successful closure of the pending claim. Renewed efforts including stronger fraud detection and investigation processes and procedures should be enacted.

Despite an outside report on the incidence of third party liability going undetected, this remains a weak area with the department. One adjuster is charged with overall responsibility for handling files with subrogation possibilities. This adjuster handles the entire case including any subrogation activities once the case has been transferred. This presumes that the individual adjusters can detect potential third party liability. File reviews indicated this is not the case. Some form of inspection of files by qualified reviewers is needed. Significant recovery potential is being lost.

Even with a vendor reviewing files for missed SIF potential, examples of opportunities missed were still found. This suggests that a more concentrated open file review timed to avoid prescription could result in increased recovery dollars to the state.

Caseloads are too high in both the Adjuster and Examiner positions. As staffing has been reduced throughout the Office of Risk Management, caseloads have been divided among remaining personnel. This

contributes in a major way to the poor results seen in the files. The industry norm is 125 for indemnity claims and 350 for examiner files. This compares to an average exceeding 200 for adjusters at Office of Risk Management and for an astounding 1250 for the examiner position. Turnover is high in the examiner position because of this unmanageable caseload. Many files that should be closed are left open particularly in the examiner files. Harried examiners fail to timely detect cases in need of adjuster attention. Until some stability can be returned to the department, an interim plan providing additional assistance is needed. This effort would more than pay for itself in the savings that could be found on more closely managed claims. Initiatives possible at either the supervisory or managerial levels aimed at dealing with this current problem were not detected.

TRANSPORTATION OVERVIEW

Staffing:

State Risk Claims Supervisor:	1
State Risk Claims Adjusters:	3
State Risk Claims Examiners:	1
Total Staff	**5**

The State Risk Claims Supervisor reports to the State Risk Claims Manager. The Transportation Department manages all first and third party automobile claims, marine claims and aircraft claims.

ADJUSTER-HANDLED TRANSPORTATION FILES: 20 REVIEWED

CATEGORY	ACCEPTABLE	MARGINAL	UNACCEPTABLE
COVERAGE	100%	0	0
INVESTIGATION	75%	5%	20%
RESERVES	60%	0	40%
DISPOSITION	65%	20%	15%
RECOVERY/SIF	1 file applied and was acceptable		
LITIGATION MANAGEMENT	9 files applied: 67%	33%	0%
OVERALL	70%	15%	15%

These results indicate an overall acceptable departmental rating. Transportation is a line of business requiring immediate attention to new claims. Independent adjusters are utilized frequently thereby staff in this department with a better factual basis than was seen in workers' compensation. The result is improved performance in allied categories such as reserving and disposition. There were some indications, usually graded marginal, of failure to push cases aggressively towards resolution. Litigation management tended to falter at times. Staff members may have pressed the assigned attorney, but responses were still not

forthcoming.

One key observation that might benefit the department was the lack of any apparent policy on property damage evaluations. Adjusters often paid from two or three estimates rather than from any actual property damage appraisal. A stated policy mandating appraisals whenever property damage exceeds a stated amount, for both first party and third party damages, would be cost effective. Generally, a professional should appraise damages exceeding $500.
There is no central recovery process to aid in either salvage or third party recovery operations. This is true of all the departments with the exception of a single dedicated representative in workers' compensation. A strong recovery unit would provide a general return on investment of 3:1 or better.

The Claims Officer has recently begun a process of end-of-assignment surveys of vendor-related activities. There is a predictable quality variance among the many approved vendors. Where superior vendors were used, superior results were seen. This new effort by the Claims Officer is timely and needed. Training in fraud and claim magnification would benefit this otherwise acceptable unit.

Bodily injury indexing can be time-consuming utilizing the Insurance Services Office (ISO) website. The Office of Risk Management is of sufficient size to warrant an integrated file download connection. This would save adjuster time.

Windshield replacement claims occupy a high percentage of the examiner's time. This is also true in the CGL department. The Office of Risk Management should consider enacting statewide contracts with approved vendors. A second recommendation would be to consider imposing a deductible on comprehensive and collision claims of $500 for all state-owned vehicles. This would reduce the number of new claims, reduce the workload on the Claims Examiner position and provide agencies with more flexibility in attending to routine and minor physical damage claims. Other states use such a concept. Even without the deductible feature, statewide contracts would reduce the internal workload and improve customer turnaround times.

The problem with legal contract management is severe and will be discussed in the Road Hazard section

PROPERTY AND CIVIL RIGHTS OVERVIEW

State Risk Claims Supervisor	1
State Risk Claims Adjusters	7
State Risk Claims Examiner:	1
Total Staff	**9**

The State Risk Claims Supervisor reports to the State Risk Claims Manager.

PROPERTY FILES: 20 REVIEWED

CATEGORY	ACCEPTABLE	MARGINAL	UNACCEPTABLE
COVERAGE	90%	5%	5%

VERIFICATION OF VALUE	90%	0	10%
VERIFICATION OF DAMAGES	70%	5%	25%
INVESTIGATION	75%	5%	20%
RESERVES	40%	10%	50%
DISPOSITION	20%	50%	30%
RECOVERY	10 files applied 80%	0	20%
OVERALL	55%	20%	25%

Twenty files composed of a mixture of examiner and adjuster files were reviewed all in the property line. This was overall a strong department exhibiting the solid approach fostered by the department's supervisor. Cases were analyzed upon receipt, values downloaded and printed, and decisions quickly made as to whether independent adjusters were needed. When needed, such vendor assistance was quickly assigned. Property lacks any consolidated recovery operation with the department supervisor handling this adjuster-level task. Some recovery possibilities were either missed or not pursued timely. Disposition was the most critical category for property. Title 36, Insurance, Part 1. Risk Management, Subpart 2. Insurance and Related Matters provides that state agencies seeking reimbursement from the Office of Risk Management for property losses have 36 months in which to repair or replace damaged property. The Office of Risk Management is precluded from reimbursing agencies until repairs or replacements have been affected. This causes increased work on the part of the Property Unit. They have to continually write agencies asking for repair invoices. Files have to be maintained for three years waiting for what may never come. The staff does have the option of paying vendors directly, but some agencies refuse to permit this. Files become dormant and are not closed in a timely manner even when the three-year limit is surpassed.

The Property Unit relies heavily on the skill set of the supervisor and one senior adjuster. This lack of a larger talent pool is a discernible threat to the long-term success of this strong department. Recently, the department began sharing one employee with Transportation. This cross training will assist with this potential problem. The supervisor needs to find some way to handle subrogation issues short of assuming personal responsibility. A supervisor's time can be better devoted to coaching, mentoring, training and providing file-level supervision when needed.

Vendors are used heavily in the Property Unit and the quality of those vendors extends across a wide continuum. The new end-of-case surveys, when properly completed, should provide the Office of Risk Management the justification it needs to remove poorly performing vendors.

Cases should be more closely monitored for potential closing opportunities. A final Statement of Loss would do much to document the ultimate manner in which cases are concluded. At times, payments are made piece-meal making any final review of the case difficult. The $250 deductible applied to property cases reduces the number of claims filed. This limit might be reconsidered with an amount of $500 being seen as preferable.

While files generally were well-handled, several files lacked any meaningful activity since assignment.

Closer supervisor review at key anniversary dates would uncover these periods of inactivity. A system-generated diary, not presently available with the current claims management system in use, could be a major factor in resolving this issue.

COMMERCIAL GENERAL LIABILITY

State Risk Claims Supervisor	1
State Risk Claims Adjusters	4
State Risk Claims Examiner	1
Total Staff	**6**

The State Risk Claims Supervisor reports to the State Risk Claims Manager.

COMMERCIAL GENERAL LIABILITY FILES: 20 REVIEWED

CATEGORY	ACCEPTABLE	MARGINAL	UNACCEPTABLE
COVERAGE	100%	0	0
INVESTIGATION	30%	5%	65%
RESERVES	25%	10%	65%
DISPOSITION	25%	10%	65%
LITIGATION MANAGEMENT	10%	0	90%
OVERALL	25%	10%	65%

This department handles general liability cases except bridge and road hazard liability claims. Staff members oversee civil rights liability cases handled by the two New Orleans representatives. Staff members perform no investigations. Independent adjuster assignments can be made. Most cases are in suit when received, and independent adjuster assignments are not routinely made unless the defense attorney requests particular investigation.

Essentially, once a case goes into suit, all activities are directed by the attorney. This includes settlement discussions. This abandonment to the defense attorney is the chief cause for the escalating defense costs being seen throughout the Office of Risk Management. This is the accepted mode of behavior within the liability units. Adjusters do not contact plaintiff attorneys directly to discuss settlement. Investigation is often the result of protracted and expensive discovery proceedings performed by the defense counsel. Lacking early information in the case, Office of Risk Management personnel cannot properly evaluate liability. Reserves are often found to be low late in the case. Other than occasional requests for status, there is really no litigation management performed. Claim representatives do spend considerable time reviewing legal bills and making efforts to reduce them. Contracts with attorneys are usually inadequate in the first instance and must be extended several times during the life of the case.

If the job of an adjuster is to investigate claims, set reserves, develop action plans for the successful resolution of a case and manage litigation, then a question arises as to the nature of Office of Risk Management adjusters' job duties on liability cases in litigation. Adjusters typically perform none of these tasks. There is little, if any, supervisory direction in any of the files reviewed. Until the defense attorney provides a Request for Settlement Authority, there is generally little, if any, activity in the case by the claim adjuster except for the paying of invoices related to the litigation. Reserves lack credibility and cannot be considered meaningful on liability cases.

Cases are not being classified according to type:

Type 1: No Liability

Type 2: Some Monetary Value

Type 3: Unknown Liability

When using this typing process, the actual defense strategy associated with each case becomes more obvious. For Type 1 cases, the strategy is to bring the non-meritorious case to trial as soon as possible. All defense preparations proceed quickly. Counsel is instructed to generally not agree to continuations of the case. Type 2 cases involve a legal defense strategy of only doing those immediate items that will assist the claims adjuster in properly evaluating the case for settlement purposes. The adjuster keeping the defense attorney informed of all developments should handle settlement negotiations. Type 3 cases involve using discovery, subpoena power, etc. to help develop the case to either a Type 1 or Type 2 classification. This methodology if employed would reduce the dependence of Office of Risk Management on defense counsel. Attorneys should be allowed to provide activities that can only be provided by members of the BAR. The adjuster while maintaining close contact with defense counsel should undertake all other activities.

Prompt investigation of all claims and preservation and documentation of evidence is the duty of a professionally managed claim department. Many of these duties are not occurring at Office of Risk Management. Opportunities to quickly resolve deserving cases are being missed. This results in an increased need for defense counsel. With the Attorney General's office generally limiting case load of their attorneys to a maximum of 70 files, for every additional 70 cases open and in suit, you incur the full cost of one additional attorney plus related expenses and supervisory overhead. A similar cost spiral can be seen as adjuster caseload is allowed to grow.

The supervisor in this unit appears knowledgeable and capable of leading this unit. The lack of a clear vision of how the Office of Risk Management will efficiently operate is hindering the office from evolving into a "best practices" organization. Staffing reductions without related planning from management to properly deal with the short-term implications of such reductions has placed a further burden upon the department. Both supervisor and adjuster time is inordinately spent performing more mundane and even clerical-level tasks. The lack of in-house Office of Risk Management counsel leaves legal bill review to the adjusters who are ill-trained to carry out this task. Training limitations further compound all problems associated with commercial general liability. Decision points should be reached within 90 days of assignment, yet are taking years to develop.

Settlement authority is very restrictive at the Office of Risk Management. It is seen as their number one internal fraud control. Such reliance upon numerous individuals and committees is time-consuming at best, and at worst can dilute responsibility for the ultimate outcomes on

pending claim files. The lack of departmental operating plans designed to help Office of Risk Management achieve their strategic plans is a further hindrance to any successful operation of this department. Without clearly defined goals and objectives, success is impossible to measure. The lack of quantifiable computer-generated reports available to the supervisor on a regular basis adds to the managerial issues within the unit. The current computer system is not suited to providing real-time, meaningful management reports. The lack of detailed data being entered into the system will make historical comparisons difficult even should a new claims computer system come on-line.

ROAD HAZARDS OVERVIEW

State Risk Claims Manager	1
State Risk Claims Supervisors	2
State Risk Claims Adjusters	9
State Risk Claims Examiners	1
Total Staff	**13**

The State Risk Claims Manager reports to the State Risk Claims Officer.

BRIDGES AND ROAD HAZARD LIABILITY FILES: 20 REVIEWED

CATEGORY	ACCEPTABLE	MARGINAL	UNACCEPTABLE
COVERAGE	100%	0	0
INVESTIGATION	50%	25%	25%
RESERVES	50%	10%	40%
DISPOSITION	60%	15%	25%
LITIGATION MANAGEMENT	55%	5%	40%
OVERALL	80%	5%	15%

This department consists of a manager and one supervisor. The manager is also over medical malpractice. This department accounts for more claim dollar expenditures than any other department. Many of their cases involve high exposures and almost all new cases are in suit. Due to the complexity of many of these cases, and unlike CGL, scoring of reviewed files was less demanding in the areas of disposition and litigation management. There is necessarily a heavy dependence upon discovery to determine the facts of these claims. The key issue in this department is evaluation. Many of the claims presented would appear to lack evidence of liability on the part of the state. State judges are inclined to be lenient with severely injured plaintiffs who lack any other "deep pocket" from which to recover. The department attempts to provide strong defenses in most of these cases. Settlements are difficult with parties typically demanding sums that are beyond the realm of compromise.

Reserves were inadequate or late developing in many of the cases. It is recommended that more realistic reserves be set given the history with these type claims. Reserves should not be construed as anything approaching settlement value, but, rather, should reflect the likely exposure to the state.

The department manager has worked diligently to put together an on-line process and procedure manual. An innovative program using selected and especially trained state troopers to investigate high-exposure potential claims even before such claims surface promises improved results for the future. Changes in tort liability law have reduced both the frequency and severity of newer claims, but shock verdicts are offsetting this. The department essentially services one customer: DOTD. The manager is a member of a safety task force. It is this type of closer customer contact that can allow increasing reductions in the actual incidence of claims. Caseloads are high. Opportunities for settlement were observed missed generally in the earlier, year one and year two, stages of claims. Typing claims would have strategic value for this department as well as for CGL. Innovative settlement practices such as settlement days, drop-checks, and creatively structured releases would help reduce the total loss dollar payout. All of these practices involve investments in time, a commodity short in this unit with high average caseloads.

MEDICAL MALPRACTICE OVERVIEW

State Risk Claims Supervisors	2
State Risk Claims Adjusters	7
State Risk Claims Examiners	1
Total Staff	**10**

Only ten claim files from this department were reviewed. The review was curtailed after finding all ten files strong in all categories. Cases are invariably reserved to reflect exposure. The personnel in this unit are knowledgeable, responsive, and very capable in their specialized field. The claim overload is greatest in this department and is the only real threat to continued strong performance. While there have been reductions in adjuster staffing, the department continues to function with two supervisors. There are only enough direct reports to justify one such supervisor.

Medical malpractice claims against the state are governed by special statutory language. This has the effect of lengthening the time it takes a typical file to move from initial claim reporting to getting a claim ready for evaluation. This is beyond the control of the claims personnel. Some possible changes in the statutory wording was discussed that might accelerate processing such claims. A “special project team” might be formed to further investigate this.

The staff is to be commended on maintaining a very strong work ethic despite the increasingly difficult caseload. Due to specialization, stronger support from the DRL than was seen here than in other liability cases. This suggests further specialization might similarly benefit other lines of business.

This unit is also encouraged to develop a closer working relationship with Loss Prevention. Currently there is no specialized loss prevention effort directed at medical malpractice. This is an opportunity that should not be overlooked by the Office of Risk Management.

During the assessment process, information was developed suggesting that coverage is a troublesome area within medical malpractice. Each state agency is supposed to provide a list of locations at which agency personnel might be employed. Some agencies have not complied

with this request. The Medical Review Panel endeavors to determine the medical provider's true relationship in each claim presented. Agencies are being less than cooperative in this regard and at times attempt to circumvent such inquiries. This represents another area for a "special project team" to be composed of representatives of the Medical Review Panel and Patient Compensation Fund as well as agency personnel. Medical providers often provide services for the state as well as for separate, non-state entities. The state should not be providing medical malpractice coverage for incidents unrelated to the state's business.

Accounting Unit

This unit is managed by Pamela Whitesides and is comprised of:

Accountant Manager 1	1
Accountant 3	2
Accountant 2	1
Accountant Technician	3
Accounting Specialist 2	1
Accounting Specialist 1	2
Contracts/Grants Rev. Supervisor	1
Contracts/Grants Rev. 2	2
State Risk Audit & Statistics Supervisor	1
Statistical Technician 1	1
Office Manager 2	1
Student Worker	2
Total Staff	**18**

SUMMARY OF FINDINGS AND RECOMMENDATIONS

The following subsections summarize the overall findings and recommendations generated as a result of this assessment.

OVERVIEW

The mission of the Office of Risk Management is to develop, direct and administer a cost-effective and comprehensive risk management program for all state agencies, boards and commissions of the State of Louisiana and any other entity for which the state has an equity interest, in order to preserve and protect the assets of the State of Louisiana. To achieve this mission, the accounting function should generate, in the most cost effective method available, historical data of transactions which have occurred in such a way as to give management a clear picture of the nature and amount of the transactions. In addition, procedures used to process information should contain internal controls not only to prevent inaccuracies in the data provided to management, but to detect any fraudulent activity. Accounting and other related reports generated in the Accounting Unit of Office of Risk Management must provide management with accurate data to determine on a timely basis if there is an area requires immediate attention.

SCOPE OF ASSESSMENT

The **METHODS** Project Team has reviewed procedures, reports and forms, personnel training, computer systems and programs. Each unit of the Office of Risk Management supports the work of the other. Proper procedures used in the Claims Unit ensure that the data processed in the Accounting Unit is accurate and proper.

This assessment consisted of interviews with accounting personnel and the review of actual step-by-step procedures used to perform daily tasks. Written documentation of process procedures were obtained wherever possible and compared to actual job functions. Flowcharts have been prepared for certain procedures to determine if the flow of data was consistent with actual work being performed. Some accounting personnel have prepared written procedures for their own use because training was not available and departmental procedures have not been updated for several years.

After determining what job processes were being performed, the processes were analyzed to determine if:

1. the procedures contained adequate internal controls;
2. the paperwork flow was reasonable;
3. the use of computer technology was being used wherever possible to reduce manual input and eliminate duplication of tasks; and
4. the need for hard copy data files could be reduced or eliminated.

This assessment was not conducted to determine if any fraudulent activities had occurred, but focused on whether sufficient internal controls were in place to detect deviations from the norm which may indicate the existence of fraud. If it was determined that a particular process did not offer the internal control necessary to detect or prevent an improper transaction from being conducted, the process was discussed with the Accounting Unit head. Immediate action was taken to modify the process to include enhanced controls. Suggestions which could be instituted with a reasonable amount of effort have been made and reviewed with the personnel affected by the change. Other suggestions which will affect the processes performed by several personnel will require the input of those concerned before completion of the changes. All suggested changes have been well received by the accounting staff.

FINDINGS

An initial meeting with the unit head was performed on January 24, 2002. It was determined that regularly scheduled meetings with accounting supervisors were not being conducted. One of the prerequisites of a well run department is to properly communicate with the staff to discuss the conduct of the departments business. To achieve the mission of the department it is necessary that all personnel have some input into the operation of the department. As a result of this assessment, regular meetings are now being conducted an each supervisor is in turn meeting with the personnel under his/her charge.

A procedure for identifying repetitive errors or omissions was not in place. The identification of recurring errors is necessary to see if a process is inadequate or there is a consistent human error. Processes then can be changed and personnel can be trained.

There appears to be a lack of training of new personnel because of work backlogs. Procedure manuals are outdated and as new personnel come on board, they write their own procedures as they conduct the job function. Few have an overall view of the functions performed in the accounting office. This results in a lack of understanding in the needs of other employees.

The Accounting Unit uses several computer programs to perform its tasks. Much of the work performed is generated on *Microsoft Excel* spreadsheets and *Microsoft Access* databases. Copy and paste techniques are used to post to *Corporate Systems* software in many instances. Only a few personnel have the technical knowledge to make suggestions for improvements in using *Microsoft Excel* and *Microsoft Access* to eliminate redundancy in the processes.

Manual preparation of input forms produces errors in input to computer systems from transpositions as well as the possibility of incomplete data being transmitted for data entry.

Members of the Accounting Unit believes it is performing acceptably but that opinion is not widely shared. Interviewees indicated open dismay and even hostility directed at an Accounting Unit that most perceived to have grown at the expense of other, more deserving units. Solutions to routine problems invariably lead to more people. Tasks were delegated back to other units even as useful services were being cut back. There is little open communication with those in the Claims Unit wondering how accounting staff even knows who is doing what at a given time.

In actuality, the Accounting Unit is probably not operating much differently than the other Office of Risk Management units. The difference is that in the Accounting Unit, everything is open, easily seen and clearly defined. Prior occurrences of internal fraud was not seen to have been an accounting issue. This underscores this unit's lack of any real or perceived objective of analyzing and trending loss results. This lack of quantification has aided the deterioration in useful case reserving. Spend reports that were furnished monthly at one time now have stopped all together. "They all know they can ask for reports at anytime" is the response usually provided. Again, no responsibility within the unit to help *control* results. The Accounting Unit is focused on tasks to be performed. These tasks take all of the unit's attention because the tasks are all so difficult to perform, easily done with errors and so labor-intensive. There is little time left for planning, improvement, introspection or analysis.

Internal controls are presumed to be "somebody else's problem". Otherwise, how could this unit have allowed its own staff to enjoy the luxury of changing payee names and addresses even as they processed claim payments? The Accounting Unit lacks a quality perspective. This unit has failed to provide the Office of Risk Management with solid analytical information gleaned from the processes it performs. Ratio analysis, exception reports and detailed inspections are seldom being provided.

As with other units, housekeeping in this paper-intensive environment is decidedly poor. Professionalism, the very heart of Accounting, is lacking. The supervisory team within this unit will be challenged to make the kind of necessary changes needed in their environment.

RECOMMENDATIONS

1. Change in Method of Obtaining Operating Cash for Claim and General Administrative Costs

The current method of obtaining cash for claim payments and operating expenses requires payments from the various units for "Premium Payments" based upon criteria established by the Underwriting Unit as well as funding from the state for the Office of Risk Management operating budget. This requires calculations by the Underwriting Unit for premium amounts and various other analyses for determining the amount of funds requested from the state government for the operations of Office of Risk Management.

Realistically, the amount requested for the budget is on a "cash needs" basis and the budget requests are adjusted from actuarial methods of determining claim payment needs to a formulated method using prior year claim payments as a basis for budget request. Since the "billings" to units for "policy premiums" does not represent the actual requests for funds, it is suggested that the claims and Office of Risk Management operating expenses be funded from the total budgeted funds on an impress method, that is, funds are reimbursed from budgeted amounts as paid out. This method while much simpler should preserve the accounting for expenditures necessary to meet federal guidelines for matching funds.

This unit would account for claim payments as paid and allocate general expenses on a basis of percentages of monthly transactions performed by the Claims Unit and Accounting Unit for servicing the various agencies payments. This would eliminate the accounting requirement for premium billings, actual premium collections and interdepartmental transfers for premiums collected. This process still retains the necessary accounting trail relating payments to source agencies. Premiums would continue to be based on actuarial calculations to meet federal guidelines.

2. Change in the Accounting System Will Improve Operations

The claims accounting system currently in place requires the use of additional programs to properly provide internal controls for the operation of the accounting and claims system. Because of this, work is duplicated, and many management reports are generated, not from the claims and accounting software directly, but from the "cut and paste" method of transferring data to spreadsheets and data bases. The use of other software on the market which can extract data on an as needed basis in the format required for internal control and management would reduce the workload and put the accounting on a more business like basis.

Accounting is presently processing approximately 850 to 1,000 monthly contract payments, 150 regular payable invoice payments and five to six *Corvel* fee payments. The Claims Unit is processing between 4000 and 5000 *Corvel* claim payments per month. Contract payments are processed with several approval phases that could be revised with a change in the recording process, eliminating some steps in the payment process and greatly reducing the process time. It would seem reasonable that two individuals in accounting could process the contract setups, ISIS contract payments and regular payables and *Corvel* fee invoices if the proper accounting system were used. Working with *Corporate Systems* and state IT personnel, electronic interfaces could be established between these various systems. Until this is accomplished, major savings from process improvements cannot be realized. The cost of these interchanges should certainly be no more than the expected first year savings realized once the interfaces are in place. Savings in subsequent years would accrue to the Office of Risk Management.

If the need for premium processing were eliminated, the only funds to be deposited would be second injury, subrogation and reinsurance receipts. Impressed funds would be deposited directly through the state system. This would greatly reduce the time now being spent in accounting for cash receipts. Other personnel would still be needed in the Accounting Unit for void transactions and bank account reconciliations to maintain proper internal control.

Properly tuned with the right claims processing software, the accounting staff should be able to process payments, process receipts, reconcile accounts, prepare management analysis with a staff of seven people consisting of one receptionist; four individuals to process *ISIS* payments, regular accounts payable, *Corvel* fees, cash receipts and bank reconciliations; one supervisor; and one overall manager for review and

coordination with other units of Office of Risk Management. The Accounting Unit currently employs eighteen people and generates another 1960 hours of annual overtime pay.

3. Some Improvements Possible with No Change in Accounting System

In the event there is no change in the accounting system, reduction in time and costs can still be achieved by changing the process flow of the work, elimination of unnecessary reports and approval processes and the utilization of computerized applications to prepare forms, reports and checklists. Duplication of records is very costly in both time and materials and can be greatly reduced by maintaining data in software applications that can be accessed directly by concerned personnel.

Nineteen hundred sixty hours of overtime was accumulated by accounting personnel this fiscal year. This should be eliminated. Accounting made 31,422 copies (not including printed documents). Paper cost is negligible (probably less than $1,000) but unneeded copies use valuable employee time. The dependency on reams of paper within this unit inevitably leads to loss of important documents, data entry errors and considerable production time spent just looking for needed documents. Offices are characterized by stacks of documents with large volumes of seldom-used documents taking up file cabinet space. Other units within the Office of Risk Management could benefit through improved computerized interfaces with accounting to greatly reduce the overall costs of producing unneeded copies. Total savings which can be achieved if all systems are revised to interface departmentally cannot be accurately quantified until, and if, the necessary changes are made and the backlog of work is eliminated.

Additional recommendations include:

1. The first step in correcting recurring errors or omissions is to identify and quantify the type of error. Accounting personnel should maintain a log of errors as they perform their daily tasks. The log should describe the error, noting the date, the exception, the individual supplying the original incorrect data, how the error was corrected and any other pertinent remarks. This data should then be accumulated in a log to determine the frequency and type of error occurring. Once a category of error types is established, the log should be prepared showing common error types and a check list log should then be used by each employee. Once an error-pattern has been established, department heads should make the necessary changes to procedures or train personnel in the proper preparation of the source data. (This change was put into effect 01/28/2002.)

2. The current procedure requires the preparation of a manual log for checks received in the mail room. This report is copied and the checks are processed by the accounts receivable clerk. Certain checks require adjuster attention before deposit to the Office of Risk Management bank account or some other action. A form request for disposition instructions is prepared for each check requiring attention, logs are prepared, paperwork is copied and incomplete receipt logs are filed until completed. It is suggested that the check received log be prepared in either a *Microsoft Excel* spreadsheet or a *Microsoft Access* table. The internal forms required for disposition instructions can then be completed automatically. Unresolved items can be audited more readily and other input reports can be prepared without additional manual entry. As resolutions are achieved, the disposition data can be entered in the computer for printout as needed. Deposit slips can be prepared automatically. This would lead to reduced duplication of data, reduced copies, reduced filing time, reduced filing space, no transposition errors, enhanced deposit detail, reduced employee time and better control over outstanding transactions.

3. The current procedure calls for manual scan or utilization of features in *Microsoft Excel* to search for specific check transactions. Manual totals are put on reports after compiling data. The clerk handling this procedure should be trained in the use of the filter function to automatically produce the data needed. This would lead to reduced omission errors, report for checks needing have special handling can be developed automatically and reduces time for special circumstances.

4. A check batch log is maintained in *Microsoft Excel*. The "void check" procedure calls for a check register code be entered when voiding checks. The check register code may be altered to use the check issue date and account distribution code so that if the check register code is not on the check, it can be determined from the check face without maintaining a separate spreadsheet log. This would save lookup time as well as time spent on maintaining the log. Data is then readily available on each check.

5. It was noted that the payee name and address can be changed on claim checks with proper authorization. There is no verification of changes made to the authorization form after the change is made. Checks are issued with the changed data. A daily transaction report is prepared in the Accounting Unit. This report is coded as to the type of change, from and to. It is suggested that a report for name and/or address changes be prepared from the claims management system to confirm authorization of such changes. Approved change sheets should be compared to the change report and a copy of the approval should be attached to the change report.

6. There needs to be an inter-departmental committee established to review the needs of management in all areas of the Office of Risk Management. Data requirements must be established by upper management so that the department heads can establish a proper flow of information to achieve the requirements of upper management. Schedules, forms and other data input must be integrated with all sections of Office of Risk Management to eliminate wasted time and materials and to ensure that the data provided is accurate and useful. Statements and reports should be established to minimize the time involved in processing, analyzing and managing the operations of the units within the Office of Risk Management. Once this has been achieved, the operational costs in all units will be reduced.

7. A series of exception reports should be designed and implemented as a further means of internal control. Examples might include (1) claims with outstanding reserves within 20% of paid amounts (2) new claim frequency deviations of more than 10% by claim department on a monthly basis (3) claim payments made greater than X% (daily or weekly report) (4) variations of more than 5% in amounts paid by payable categories on a monthly basis (5) listings of claims recording changes in name or address by adjuster on a weekly basis.

Overview of Current Risks

The following observed potential trends helped to define the impetus for the Office of Risk Management to optimize its organizational focus and structure. They also highlight the challenges faced and the obvious implications of lack of action.

There exists considerable potential within the Office of Risk Management to simultaneously improve internal operations, bolster staff morale and reduce loss costs. In some cases, it is likely that a reorganization of resources can provide immediate aid. Relatively low cost, short timeframe technology projects are available to further provide immediate cost savings and staff support. Various processes and procedures can be streamlined to provide more staff time for essential functional activities. Technology can likely be updated to best practice standards without costing much more than the current license and maintenance fees for what appears to be a severely outdated and unresponsive risk management information system.

Eight overarching trends emerge during the early stages of this assessment:

a. Personnel shortages resulting from budget reductions have had a major impact on daily operations affecting customer service, quality, efficiency and staff morale.

b. There is a lack of confidence in the management team's collective capabilities extending from supervisory positions in certain departments to the "Fourth Floor" executive management team.

c. A lack of basic training is a further cause of deteriorating quality and efficiency.

d. A lack of close cooperation and communication between the Claim and Loss Prevention Units and the client base is resulting in lost opportunities to assist in loss prevention and loss containment.

e. The general management approach is non-quantitative in its orientation.

f. Personnel throughout the organization generally seem dedicated to serving their customer base and sincerely want to see the department perform at a higher level of both internal and external satisfaction.

g. Technology used to assist staff in their essential job performance is considered grossly inadequate.

h. Lack of internal financial controls.

The following subsections take these eight trends, group them into three major categories and include a summary of findings along with implications for further study, if necessary:

- Staffing (*items a – f*)
- Technology and Business Intelligence (*item g*)
- Internal Financial Controls (*item h*)

Staffing

Staffing-related issues are perceived as the number one priority within the Office of Risk Management. The approved level of staffing has become the dominant theme throughout Office of Risk Management at all levels.

A. Table of Organization (TO) and Use of Vendors

The Office of Risk Management requested a TO of 130 and was granted 128 slots of which approximately ten remain vacant. All interviews have uncovered a belief that current staffing levels have reduced operating capabilities to emergency levels. For example, supervisors in the Claims Unit readily admit that adjusters have been transformed into "paper shufflers". Claims investigations, when performed, are routinely done by vendors and not by the adjusters. SIF recoveries can be obtained directly without incurring vendor cost if recognized and filed with the Office of Workers' Compensation (OWC) within the first six days following receipt of a claim. Adjusters, with management approval, are flagging recognized cases to the vendor incurring a 15% surcharge on all monies collected on each file over the next seven years. Personal field contact by Baton Rouge-based adjusters, considered a tactical strength just two years ago, has virtually ceased. Bill payment timeliness, mandated to be accomplished within sixty days by law, is deteriorating and subjecting the Office of Risk Management to increased penalties and attorney fees. This suggests that internal cost shifting may be occurring with ultimate operating costs increasing rather than decreasing.

Staff interviews consistently uncovered declining morale. Most believe that high quality personnel are leaving or preparing to leave. Exit interviews conducted with confirmed this is occurring. Employees who remain are seeking transfers to other departments or to less stressful positions within the Office of Risk Management. This constant shifting of staff is accelerating organizational stress.

Some staff members believe claim backlogs are growing. Backlogs in a claim environment often result in:

- A decline in customer service and satisfaction
- A reduction in timely claim closures
- An increase in telephone and mail inquiries
- Less than optimal negotiated claim settlements (from the perspective of the state)
- Lack of attention to claim basics (i.e., effective reserving, investigation in addition to subrogation identification and pursuit, etc.)

Implications for further study:

- Monitor average caseloads/workloads by department and compare to optimal levels. Determine optimal staffing variances.
- Determine cause of slow claim closure rate and recommend short-term and intermediate-

term solutions.

- Analyze ROI for integrated risk management information system including claims document management system, data warehouse/business intelligence system, loss prevention module, accounting system.

- Pursue strategy with assistance from the CPTP (functional and supervisory).

B. Lack of Confidence in Management Team

The former executive management team and current unit-level management/supervisory staff has become the primary focus of the rank and file employees. Staff members see supervisory personnel as key strengths in some units but major weaknesses in others. It should be expected that most individuals would find it difficult to respect and take direction from a supervisor lacking in functional and managerial skills.

Staff members described incidents of supervisory tendencies toward favoritism, intimidation and gender discrimination. There is a perception that managers "stick together" to suppress and/or minimize perceived managerial incompetence or misconduct. Any one of these issues, if allowed to continue unchecked or unresolved, will have a serious negative impact on overall team spirit and cooperation.

Supervisory and management personnel had witnessed a gulf emerging over the past two years between the former executive management team and the operational management team. Communication is universally seen as "top-down" with little if any regard for knowledge or opinions of the actual operating unit personnel. Information is seldom shared. This is a characteristic of a traditional, hierarchical organizational structure where power is equated to knowledge. There is little team spirit or team-based efforts visible. There is an expectancy of improvement soon to come given the recent executive management changes.

Implications for further study:

- Organizational strategies designed to reduce layers of management and simultaneously increase customer service and operational efficiency should be developed with qualified professional assistance.

- Review managerial components of planning, organizing, staffing, directing and controlling and take advantage of opportunities to increase credibility of management team.

- Continue to monitor and actively investigate claims of favoritism, intimidation and discrimination.

C. Lack of Training Permeates Office of Risk Management Units

Compounded by staff reductions without reorganization to cope with such changes, training opportunities has been allowed to decline. New hires or internal transfers often fill new positions requiring complete training in their new job functions. Interviews to date have demonstrated that such personnel are given the basic personnel processing, assigned to their new job duties often including entire claims caseloads and left

to their own devices. There is a lack of even the most basic of orientation programs. Attendance at conferences and seminars was significantly limited. Training that is available at no cost has not been effectively utilized. Vendors and medical providers available for in-service training are not being invited to present informational topics to the claims staff. There is no concept of budgeted training time for the staff with annual plans completed. Training generally will comprise 4 - 7% or more of a competent staff member's available time. Without a concept of a "learning organization", incremental improvements are reduced. Interviews with Claims Unit personnel in their job for over one year demonstrated a lack of even rudimentary knowledge. Senior personnel are increasingly being given the more complex tasks resulting not only in high caseloads but disproportionately complex caseloads.

Another example of what the lack of training can mean to an organization is the State Risk Audit & Statistics Supervisor. This individual has been transformed into the key source of ad hoc reports generated using data held in *Corporate Systems* data repositories. These numerous requests originate from throughout the Office of Risk Management as well as externally (e.g., client agencies, Division of Administration executive staff, Office of Planning & Budget, the Legislature, etc.). This has resulted in this individual being unable to fully utilize his formal training as a Certified Public Accountant and Internal Auditor which is what he was originally hired to do. This individual and the Accounting Unit Manager are the only two individuals within the Office of Risk Management who have had formal training provided by *Corporate System* to enable them to retrieve data from the system. These key personnel cannot long persist in such an environment that disproportionately assigns tasks to those capable of performing without providing appropriate training for all staff members.

Implications for further study:

- Consider partnering with the CPTP to develop a Training Plan incorporating organizational quality assessments and skill gap analyses.
- Catalog and prioritize training needs by unit and by function.
- Recommend plan to transform Office of Risk Management into "learning organization".

D. Office of Risk Management is Internally Focused

The business units with the Office of Risk Management are organized along traditional, internal lines. Organization is by geographic location of claimant, alpha structure of claimant's name, straight claim rotation or departmental function. Industry best practice is to organize, indeed to structure the entire operation, along customer-driven needs. A dedicated customer team serving only certain designated clients and charged with the mission of controlling and reducing total customer cost of risk would be expected to outperform any other possible organizational design. Communication with customers in ways expected to facilitate operating objectives has not been considered. The idea of customers being provided with quarterly cost of loss scorecards and assisted via quarterly meetings with their team in meeting mutually agreed upon objectives could become a powerful cost containment tool to the Office of Risk Management. A transition to such a direct approach would require planning, project management expertise and leadership.

Implications for further study:

- Conduct periodic client interviews to determine current perspective of Office of Risk Management support.
- Consider and analyze alternatives to facilitate closer customer interaction and support.
- Tabulate loss cost per client and determine estimates of potential savings from organizational realignment based on client focus.

E. Lack of a Quantitative Management Approach

This is a typical *"chicken and egg"* problem. A lack of meaningful numerical data has dissuaded management from moving to a more quantified approach to managing their responsibilities. Not being accustomed to such a management style, these same managers lack the initiative to seek out ways to obtain this necessary information. Managers and supervisors seem unable to answer such basic workload and productivity questions as current closing ratio compared to prior year, pending claim totals compared to prior year, litigation closing rates, percent of litigated cases actually going to trial and win/loss ratio of litigated cases.

Budget reconciliation reports are not getting to the unit managers and supervisors. Budgets are seen as unrealistic. No effort is being made at the operational level to analyze expenditures or make efforts to control them. In workers' compensation, for example, supervisors have no idea how many cases are being assigned to medical or vocational case management or the overall costs involved. The only report available to the manager or supervisor is the "Monthly Report". This is a useful report but it lacks depth. Special projects designed to probe into specific issues seem to be lacking unless performed exclusively by executive management.

Implications for further study:

- Decompose Critical Success Factors for specific units.
- Determine data necessary to provide information necessary to measure attainment of objectives.
- Identify training and tools necessary to implement quantitative managerial approach across Office of Risk Management.
- Coordinate departmental approach with current individual performance measurement approach.

F. Staff Motivation and Process Change

Personnel throughout the organization generally seem dedicated to serving their customer base and sincerely want to see the department perform at a higher level of both internal

and external satisfaction. Outstanding examples of initiative and dedication to departmental goals have already been uncovered. *"Saturday Morning Claims Parties"* are being conducted to cope with staffing overloads. This work is being performed without extra remuneration and on a voluntary basis. One department has produced an excellent Intranet-based policy and procedure manual and is actively at work installing hyperlinks to case examples to aid the staff in their understanding of more complex processes and procedures. This has been accomplished through hard work and a cooperative spirit among different departments and at no additional incurred costs. As a result of the assessment, the Accounting Unit has streamlined its process for handling premium checks resulting in better controls being implemented also at no additional costs.

Implications for further study:

- Arrange and conduct small and large project team meetings to explore strengths, weaknesses, opportunities and threats.
- Develop short, intermediate and long-range solutions and plans to implement.
- Identify strategies to celebrate successes and to recognize individual, team and client contributions.

Technology and Business Intelligence

Closely behind staffing in priority ranking by staff, technology is also seen as grossly inadequate and a barrier to improved productivity. The *Corporate Systems* Claim Management System is viewed as a bare-bone system lacking essential claim management components. Annual maintenance costs paid to *Corporate Systems* appears to be equal to the cost to purchase and install a superior system with actual savings incurred after perhaps the initial two or three years of start-up costs. The Office of Risk Management is not a major insurance company. Its system needs more closely resemble that of a mid-sized local or regional third party administrator.

Basic management information reports are either lacking or produced in such a fashion as to require extensive re-work before the data becomes useful information. Systems are available with increased functionality and improved operational and managerial reporting capabilities for amounts that would be less than the annual maintenance fee now being paid for the current system. The lack of access to a cohesive and integrated risk management information system increases the risk of generating unreliable information due to tedious manual data mapping / cross-referencing and assimilation; multiple entry of the same data elements into different modules; and very loose referential integrity.

A rigid security scheme and the lack of an intuitive, Internet-enabled user interface also limits access to most of the system's functionality, particularly ad hoc reporting. Clients and business partners need better access to the data that would enhance their relationship with the Office of Risk Management.

Modern risk management operations can eliminate most, if not all, of traditional clerical functions such as correspondence generation and double-entry of data. Clerical support has been sharply reduced within the Office of Risk Management without the concomitant addition of automated support. This has resulted in claim professionals taking on clerical duties further reducing their focus on their core activities.

Satellite offices lack the basic system performance seen in the Baton Rouge office. Internet access and upgraded equipment are the bare minimums to facilitate effective information transfer and management.

The following diagram illustrates the optimal maturity of raw, collected data. It begins at the point of collection (operational level) and matures into wisdom (strategic level). This is the level the Office of Risk Management needs to focus its attention. Timely access to strategic data is essential to achieving strategic vision and the development of a business intelligence environment where fact-based decisions are the norm.

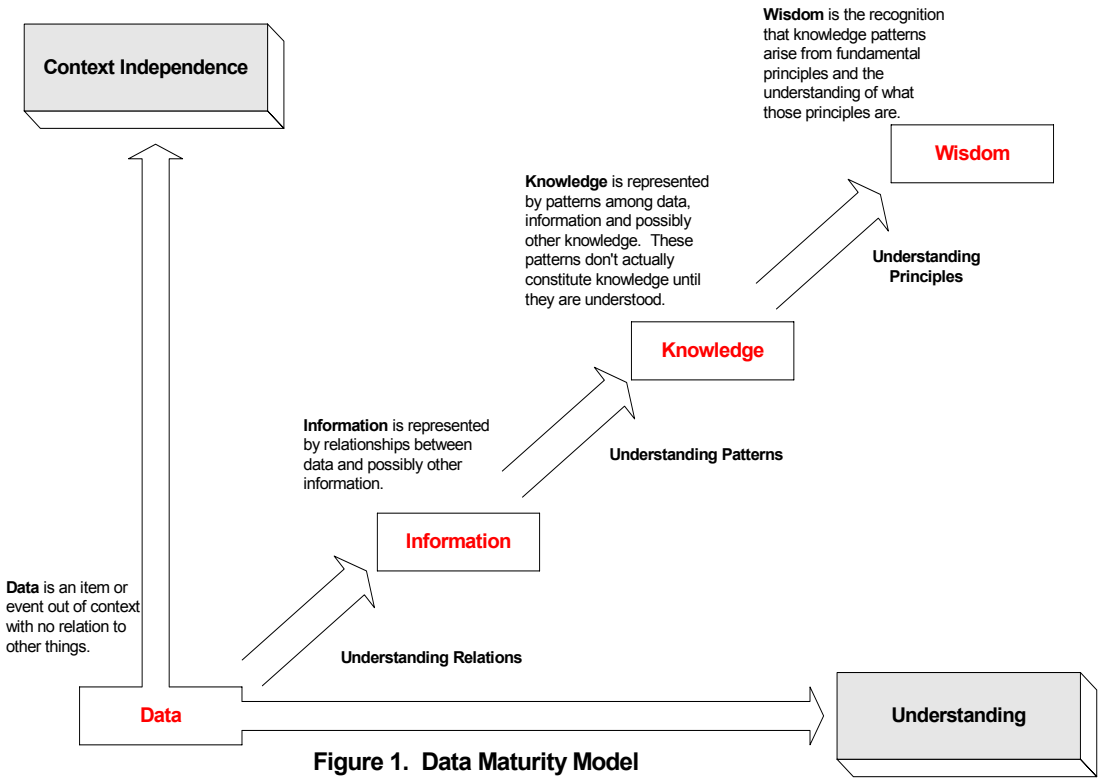


Figure 1. Data Maturity Model

Implications for further study:

- Identify and document desirable features in an integrated risk management information system.
- Review comparative systems and estimated costs acquisition plus continued operation.
- Include specific review of system needs to support satellite operations and secured, Internet access.
- Compare minimal and optimal reporting and analysis needs against ability of current system to deliver. This analysis should incorporate the applicability of a robust, dynamic business intelligence environment to support improved Internet-based analytical and presentation/reporting solutions such as a data warehouse implementation, flexible charting tools, drill-down/roll-up reporting tools, multidimensional.

The Office of Risk Management should also investigate the use of scorecards. Balanced scorecards are especially useful for:

1. **Defining and then executing the overall organization's strategy.** By identifying the key drivers of success, executing the strategy and then measuring those drivers, it is possible to develop a strategy that is more robust and execute it more effectively.

2. **Communicating effectively.** By integrating, analyzing and communicating the right information throughout the organization, staff members will be able to make the right business decisions consistent with the organization's strategic goals.

3. **Quickly identifying the root causes of potential problems and responding proactively.** Having a cause-and-effect model of how the performance measures relate to each other provides a list of "likely suspects" to quickly focus diagnostic efforts and action.

4. **Alerting decision-makers about early indicators of trouble.** A cause- and-effect model allows organizations to trace the likely downstream effects of performance issues. Such a model, for instance, could show how a sudden increase in staff turnover could affect response time, which could, in turn, affect loss exposure and client satisfaction. Identifying these issues early allows management more time to devise positive plans for mitigating the issues.

Combining integrated analytics with a balanced scorecard approach can be a powerful way to make certain the right analytics are measured, monitored and acted upon. Equally important is ensuring that the data used to drive the calculation of those analytics is:

- The right data: consistent, accurate and useful.
- Captured and presented at the right time.
- Sourced from the most appropriate systems.

An enterprise information architecture must be in place to successfully implement a balanced scorecard. This architecture needs to include a data warehouse environment that captures, manages and summarizes the source data as well as supports the analytics that are reported in the balanced scorecard. Because of the integrated nature of the balanced scorecard, the data warehouse stands as the centerpiece of the enterprise system architecture. By taking an open and modular approach, the data warehouse and scorecard systems can evolve and grow as the needs placed upon them change.

Internal Controls

Recent events within the Office of Risk Management demonstrated a lack of sufficient financial and procedural controls as well as required monitoring to prevent internal fraud and abuse. Although several incidences of fraud and collusion have been discovered over the years, little has been done to minimize the organization's exposure to such activity. In the aftermath each occurrence, financial controls were tightened presumably to prevent any reoccurrence. These controls are obviously ineffective. For example, the payment process for initiating a single $25,000 bodily injury settlement, already approved by an internal review committee stipulates that:

- a claims adjuster fills out a payment request form
- a supervisor signs off
- a manager signs off
- the Claim Officer signs off
- the State Risk Director signs off
- a clerk enters the payment
- a clerk prints and distributes a forecast report
- a supervisor double-checks the pending payment against the original paper request and signs off
- the check is ultimately prepared and distributed

Certain size payments involve a further review initiated in the Accounting Unit. This laborious and time-consuming process was essentially in place yet failed to deter the recent internal fraud activity. There is a concern that the recent prolific requirements from multiple sign-offs may be providing a false sense of security. What is needed, however, is a multi-layer of independent and overlapping controls coupled with staff diligence and compliance necessary for any chance of success.

It is difficult to understand how the sudden increase in frequency of claims in the small Road Hazards section went undetected by claims and accounting management personnel. This serves to further highlight the lack of effective quantitative orientation by current management and supervisory staff to their essential job functions.

A special emphasis should be placed on reviewing the quality of vendors and service providers particularly in the claims area. With the current successive assignment policy, vendor performance is not always carefully considered or evaluated. Additionally, this assignment process is susceptible to collusion. Careful monitoring should be done to ensure the strategy ensures that the best qualified vendor is available and that all qualified vendors have equal access.

Each unit should review and update existing policies and procedures manuals to ensure that these documents are designed to provide guidelines for the effective performance of job duties as well as ethical and professional behavior. These documents should also provide for measurable and meaningful monitoring strategies.

Implications for further study:

- The role of an Internal Auditor and the Office of State Inspector General should be reviewed and reinstituted
- A review of what appears to be a lack of appropriate controls on external claimant fraud and selection of vendors should be implemented and closely monitored.
- The design and functionality of specific exception reports should be reviewed and recommendations made for content and distribution.